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DRUG STORE NEWS

Vol. 11/No. 20 Our 61st year of serving chains, wholesalers and high-volume independents Published by Lebhar-Friedman Inc. Oct. 23, 1989

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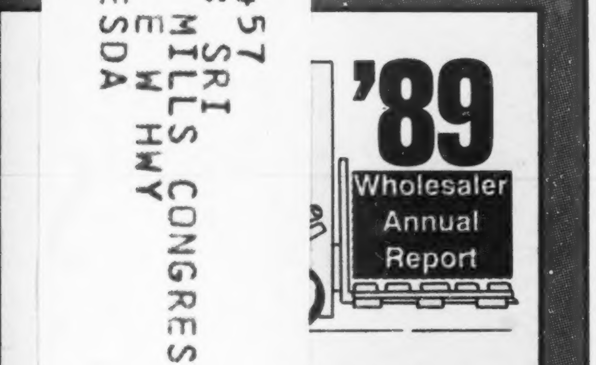

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Deep discounters hit their stride

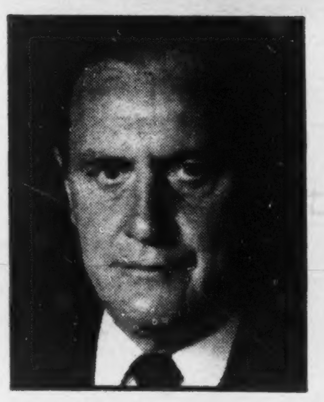
Deep discounters are plowing steadily into new markets and at the same time [illegible] millions of consumers to the off-price concept. Page 13

LATE NEWS

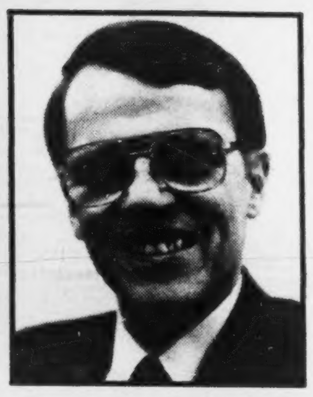
- SHIREMANSTOWN, Pa. — Rite Aid will remove video rental departments from most stores by Nov. 30. Fewer than 100 stores will retain departments, down from 1,002 currently, the company said.
- TRAVERSE CITY, Mich. — Perry Drug Stores will enter this new Michigan market, having signed leases for two stores here. One is for a new store at 14th and Division in Traverse City; the other will be in nearby Acme. Jack Robinson, Perry chairman, said the chain renewed its expansion program after a two-year halt to consolidate operations, and plans to open eight to 10 new units a year.
- TROY, Mich. — K mart Corp. will reach $50 billion in annual sales by 1995, and will open as many as 100 new stores a year by that time, chairman Joseph Antonini told investment analysts here.
- TWINSBURG, Ohio — Revco D.S. promoted Vincent Trius to director of operations for the Southern region, splitting responsibilities for more than 430 stores with Ken Hipsher.

Jorndt to be Walgreen president

Hunter named vice chairman; Brunner, Kraiss exec vps



Fred F. Canning
to retire Feb. 1st



L. Daniel Jorndt
. . . to replace him

DEERFIELD, Ill. — L. Daniel Jorndt has been elected president and chief operations officer at Walgreen, succeeding Fred F. Canning when he retires Feb. 1.

Jorndt, 48, currently senior vp and treasurer, is a veteran of Walgreens since 1963, and has held successive store, district and regional positions during his career. He was named a regional vp in 1979, and was promoted to senior vp-treasurer in 1985. He has a pharmacy degree from Drake University.

See full-year results, page 2

Canning, who has served as president the past 11 years, will continue to serve on the board of directors. He is credited with a major role in Walgreens' development into the nation's largest drug store chain, with 1,484 drug stores in 28 states and Puerto Rico. Canning, 65, joined Walgreens as a drug apprentice in 1945, and became a registered pharmacist in 1950. He was elected vp-marketing in 1972, and in 1975 was named vp for the drug store division.

Other promotions announced

Walgreens also promoted executives immediately under the president's office. The changes will create two executive vp positions, where there had been one.

Charles Hunter, 59, who had been executive vp, has been named vice chairman and will continue as chief financial officer.

Vernon Brunner, 49, senior vp-marketing, has been elevated to executive vp.

Glenn Kraiss, 56, senior vp-drug store operations, was also elected executive vp.

F&M, Phar-Mor are on the move

Minneapolis

F&M targets Minneapolis; goal of 100 stores by 1990

By James Frederick

WARREN, Mich. — F&M Distributors will push west into Minneapolis/St. Paul early next year as it drives toward the 100-store mark by the end of 1990.

The company's entry into the Twin Cities will be a rapid one, in line with the aggressive expansion strategy F&M has established in other major markets like Chicago, Washington, D.C., Baltimore and its home market of Detroit.

"When we go into a new market, we move quickly, and we're going into Minneapolis the same way next year," said Frank Newman, president and chief executive of F&M. "We'll have at least six stores open there by the end of next year."

Among them will be four units opening simultaneously on approximately April 1, he added.

In the Twin Cities, the off-price chain will compete in a drug store arena dominated by two chains, Snyder's Drug Stores and Walgreens. Two other local chains, Snyder Brothers and Thrifty/White Drug, also have strong franchises in the market.

Among deep discounters, Drug Emporium is also mulling a major expansion in the Minneapolis market. Gary Wilber, president and chief operations officer of Drug Emporium,

See **F&M** *page 41*

PHOENIX, Ariz. — Fast-growing Phar-Mor is stirring the retail pot in yet another major market as it looks to expand into this sunbelt city in coming months.

Carol Robinson, Phar-Mor's director of advertising, confirmed that the off-price drug chain was close to a deal to open stores in Phoenix and neighboring Scottsdale, Ariz. "We're actively negotiating for leases at several locations in the Phoenix area," she said. "We're also looking at locations and lease arrangements in other Western cities."

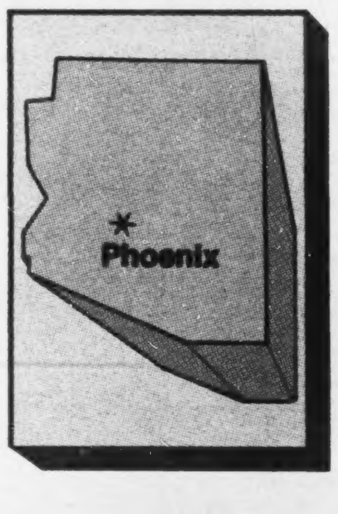
See related story on p. 16

Robinson also indicated there was nothing to keep Phar-Mor from moving as far west as California and Oregon. The chain currently operates stores as far west as Denver, where the first unit opened last February.

Although the company is not yet ready to talk about specific store sites in Phoenix, a local market source said Phar-Mor was negotiating for a site at The Scottsdale Pavilions, an unenclosed shopping mall that is about half-completed.

"The mall is outdoors and aesthetically very attractive, and the interesting thing about it is it's on Pima Indian Reservation land," said the observer. "Part of the agreement

See **Phar-Mor** *page 41*



Phar-Mor eyes Phoenix and western cities for expansion

Hook-SupeRx sells to Eckerd, leaves N.C.

CLEARWATER, Fla. — Hook-SupeRx Inc. has pulled out of North Carolina with its sale of 10 SupeRx stores to Eckerd. Local sources believe HSI decided to leave these small town markets rather than add stores here to build necessary efficiencies.

Eckerd will now operate 183 stores in North Carolina, where it vies with Revco, Rite Aid and Kerr for market share in small towns and in the metro markets of Winston-Salem, Raleigh-Durham and Charlotte.

In Winston-Salem, for example, which includes High Point, the purchase should move Eckerd into the market share lead. Prior to this deal, Eckerd's 27 stores here gave it a 24 percent share, a whisker behind Revco's 25 percent share from 42 stores, according to Metro Market Studies (MMS). The purchase gives Eckerd two additional SupeRx stores in Winston-Salem and one in High Point.

Eckerd leads in Charlotte with a 38 percent share on 49 stores, followed by Revco's 19 percent on 38 stores.

And in Raleigh-Durham, Eckerd and Revco run Nos. 2 and 3 to Kerr, which has 51 percent share, MMS reported.

Other SupeRx stores are in small towns in the north and west, including two in Burlington, and one each in Asheboro, Boone, Monroe, Shelby, and Wilkesboro.

"You need to have two to three stores per town to have efficiency" in distribution and advertising, noted one competitor. HSI, with LBO debt to consider, has braked store growth not only with SupeRx, but also at its Hook and Brooks Drug divisions.

See **SupeRx** *page 41*

Drug Store News' ***Store Manager Training and Continuing Education programs help develop store managers and pharmacists.***
For information,
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SECOND CLASS

NEWS IN BRIEF

Mastrian named SupeRx drug head

PHOENIX — James P. Mastrian has been named president and chief operating officer of the Drug Division of SupeRx of Arizona, Georgia and Alabama. Mastrian, who has held positions at Gray Drug Fair, Cabalier Drug and Peoples Drug Stores, will be responsible for the SupeRx and Medicare-Glaser Drug Stores and the home health care and optical businesses.

Cardinal names Bearman sr. vp

DUBLIN, Ohio — Cardinal Distribution recently appointed David Bearman senior vice president and chief financial officer.

Bearman, 44, comes to Cardinal from General Electric Medical Systems, a diagnostic imaging equipment division of General Electric Co. based in Milwaukee, where he was the senior financial executive. He replaces Charles E. Reiser Jr., who left Cardinal by mutual agreement for a position with Continental Office Furniture and Supply Co. of Columbus, according to George H. Bennett Jr., Cardinal vp and general counsel.

Cardinal also recently upgraded several people to vice presidencies, for areas of responsibility they had already been handling. They include Anthony J. Campanaro, vp-retail sales and marketing; William H. Bottlinger, vp-management information services (MIS); Douglas L. Moore, vp-treasurer; Anthony Woo, vp-controller; Robert E. Moss, vp-distribution planning; and Alan J. Phair, vp-customer information services.

Cosmetex set for Toronto next month

TORONTO — International Beauty Shows, Inc. will hold its first cosmetics-beauty trade show, Cosmetex, at the Metro Toronto Convention Center here Nov. 16-19. The show, which will be similar to the internationally acclaimed Cosmoprof held in Italy each year, is geared toward drug store chains, salon owners, distributors and manufacturers.

It will include a two-day seminar and a consumer trade show on its final two days. The focus will be on anticipating new growth segments and emerging beauty trends.

Silver to head NAGMR

ORLANDO, Fla. — Arthur Z. Silver at press time was expected to be installed as president of the National Association of General Merchandise Representatives (NAGMR) at the association's 41st annual convention here.

Silver, a member of the association for 13 years, is president of Silver Marketing Group Inc., headquartered in Berlin, N.J., which he founded. He has previously served on NAGMR's board and was vice president of the organization this past year.

BTS show board members named

NEW YORK — The Advisory Board of the 1990 National Back-To-School Merchandise Show gained five new members, David Thalheim, president of Thalheim Expositions, announced.

First-time members are: Nelvia McGrath, Eckerd; Jerry Gordon, F.W. Woolworth; David H. Hewitt, Binney & Smith; William R. Mason, American Greetings; and Jim Palmer, BIC Corp.

The show will be held Feb. 10-12 at the Javits Convention Center here. More than 1,000 booths will be occupied, and the show is strategically timed to precede the annual Toy Fair and Variety Merchandise Show, also held here. For information and advance buyer credentials for the BTS Show, contact Thalheim Expositions, 42 Bayview Ave., P.O. Box 4200, Manhasset, N.Y. 11030-4200; (516) 627-4000.

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Walgreen's core busines
makes fiscal '89 a recor

DEERFIELD, Ill. — Focusing on its core drug store business, Walgreen Co. delivered its 15th consecutive year of record sales and earnings for the fiscal year ended Aug. 31. Net earnings rose 19.5 percent in fiscal '89, to $154.2 million, on sales which grew 10.2 percent to $5.38 billion.

Net income in the fourth quarter rose a more modest 5.5 percent, to $33.7 million, on sales of $1.34 billion. Earnings were affected by the sale of Walgreens' private label manufacturing operations in August, which yielded a one-time pre-tax loss of $6.1 million. The loss was more than offset, however, by tighter inventory controls, which the company said added $15.3 million to pre-tax earnings.

"Walgreens is now out of all peripheral businesses and focused entirely on its fundamental goals," said chairman and chief executive Charles Walgreen III. "We want to run the best-merchandised, most technologically advanced drug stores, add about 100 stores a year, and deliver an optimum return on investment."

In effect, Walgreens is reaping the benefits of an aggressive expansion and store renovation program in effect for several years. Since the mid-1980s, the nation's No. 1 drug chain has opened or acquired 579 stores, or 40 percent of its current base of 1,484 drug stores in 28 states and Puerto Rico. Hundreds more have been remodeled.

The chain continues to add new stores at a rapid clip, giving it a constant stream of maturing stores to boost revenues and profits. In fiscal 1989, Walgreens added another 89 stores and approved a record number of prospective sites, according to the company, and renovated another 157 units.

On the drawing board in the next five years are 600 new drug stores, with capital spending pegged at $200 million in 1990 alone. Of that sum, $40 million will go toward construction of the chain's eighth distribution center in Mount Vernon, Ill., which will begin supplying units from Omaha to Cincinnati in 1991.

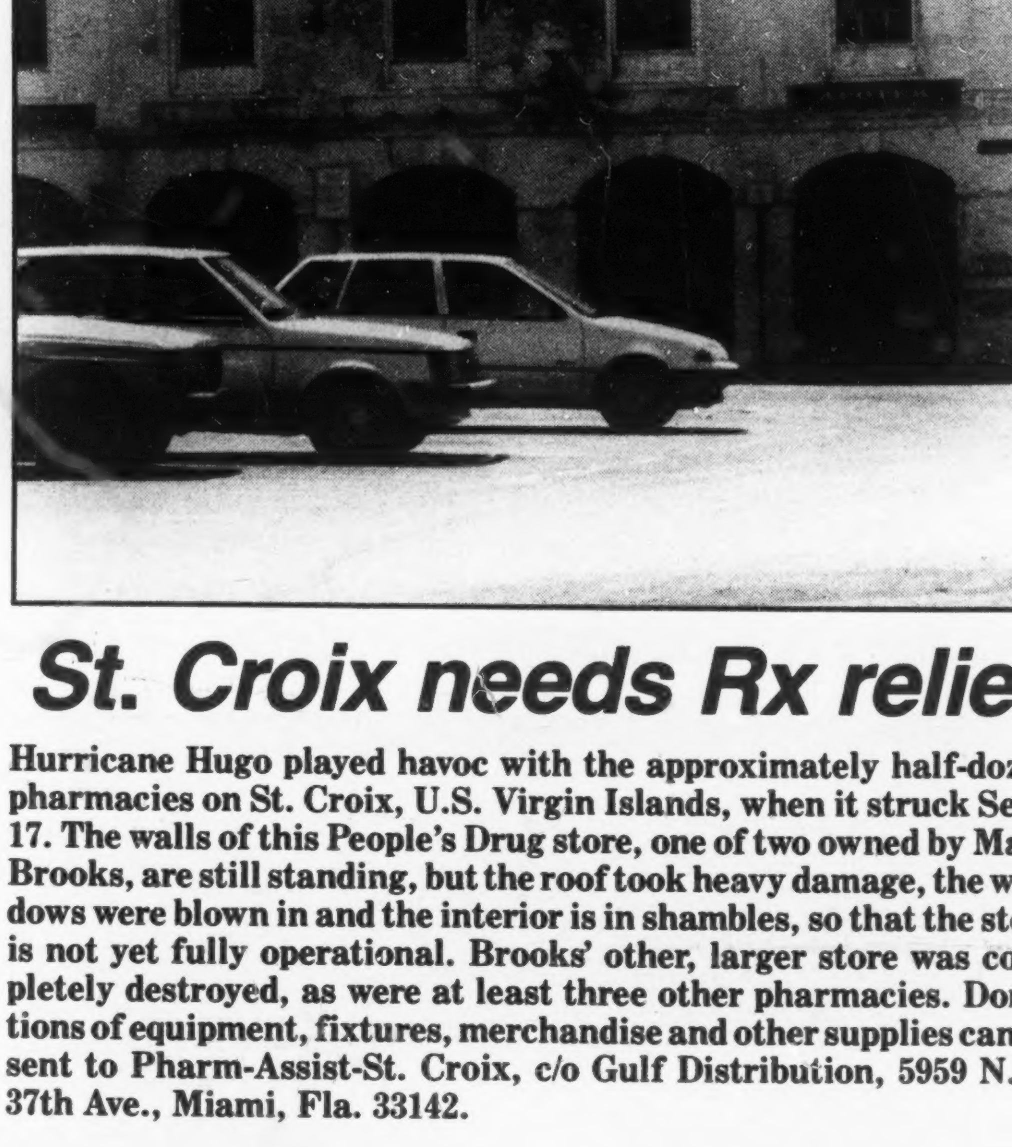
The company is also "actively seeking" a site in the Northeast for a distribution center to bolster its growing network of stores in that part of the country. Walgreens broke ground in the Northeast with its purchase of the Medi Mart chain in 1986.

Walgreens is also reaping the effects of booming sales at the pharmacy counter. For the eighth consecutive year, Rx sales grew more than 20 percent at the chain, to $1.6 billion.

"Pharmacy is now 30 percent of our total sales," said president Fred Canning. "We feel well positioned to take advantage of substantial growth predicted for pharmacy, especially in third-party programs, which pay for more than 35 percent of all retail prescriptions."

On the technology front, Walgreens continues to invest big sums in three major projects:

- Front-end scanners have been installed in 180 Chicago-
land and Fort Wayne, I
stores, with another 400 u
targeted for next year. Cha
wide scanner hookup is sla
by the end of 1991.
- SIMS, or the Strate
Inventory Management S
tem, has been rolled out in
Windsor, Wisc., distribut
center. Eventually plann
for all DCs, SIMS will h
usher in a "paperless" rece
ing system, according to ch
spokesman Tom Mammos
SIMS' next major progra
an electronic purchasing s
tem for buyers, will be in pl
this winter, he added.
- Rooftop satellite dis
have been installed at m
than 900 stores, with most
the rest of Walgreens' st
and distribution center n
work set for hookups t
year. The network will link
facets of the business for d
transmission, pharmacy co
puter linkups, electronic m
and other uses.



St. Croix needs Rx relie

**Hurricane Hugo played havoc with the approximately half-do
pharmacies on St. Croix, U.S. Virgin Islands, when it struck Se
17. The walls of this People's Drug store, one of two owned by M
Brooks, are still standing, but the roof took heavy damage, the w
dows were blown in and the interior is in shambles, so that the st
is not yet fully operational. Brooks' other, larger store was co
pletely destroyed, as were at least three other pharmacies. Do
tions of equipment, fixtures, merchandise and other supplies ca
sent to Pharm-Assist-St. Croix, c/o Gulf Distribution, 5959 N.
37th Ave., Miami, Fla. 33142.**

Rose named to DrSN's *advisory boar*

Rose

NEW YORK — Larry Rose, president and chief operations officer of Fay's, Inc., has been appointed to *Drug Store News'* board of advisors.

He will join 10 other top drug industry officials on the board, which helps *Drug Store News'* management and editorial staff identify and report on key issues facing the industry.

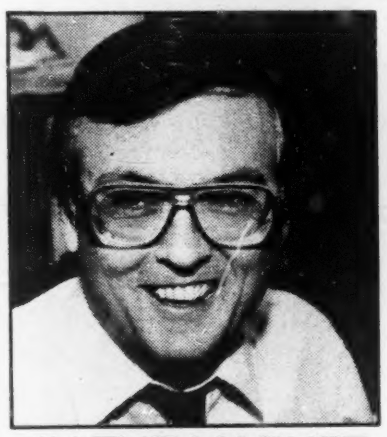
Rose, a pharmacist, began his career with Thrift Drug in 1967 as a store manager, rising to director of store operations at the Pittsburgh-based chain. In 1981, he became vp-director of marketing at Thrift, moved on to senior vp-director of marketing and merchandising, and later became executive vp-marketing, merchandising and distribution
Thrift.

In 1987, Rose joined Fay's Drug
as president and chief operations o
cer. He became president and chief
erations officer of Fay's Inc. when
company, in preparation for grow
strategies in all three of its retail d
sions, restructured last March.

Currently, three retail divisions
the company report to Rose — Fay's d
store division, under the command of presid
John Kogut; the company's Paper Cutter s
tionery division, under president David P
asci; and the Wheels Discount Auto Sup
stores, under president Michael Falcone.

OPINION

Relief effort targets St. Croix Rx'ers



IN THE MARKET

BRUCE BUCKLEY

Florida pharmacist Allen Nichol knows what it's like to lose a drug store. In 1980, the riots that erupted in Miami spilled over into Coconut Grove, where his 2,000-square-foot Grand Pharmacy was located. The store was burned to the ground.

That's one of the reasons he's now involved in the relief effort aimed at the pharmacists of St. Croix who lost their stores when Hurricane Hugo tore across the island with such devasting results. Nichol and other pharmacists in Florida and elsewhere are uniting to donate fixtures, equipment and computers they've outgrown to their St. Croix counterparts.

Nichol no longer has a store in the Miami market. Several years ago he relocated to a 4,700-square-foot pharmacy in Coral Gables. But he hasn't forgotten the help he got from fellow pharmacists in the bleak period after his store was demolished by rioters and looters. "I was basically out of business," he recalls.

Nichol was able to reestablish his practice on a very limited basis within a week, but longer term it was the contributions of equipment and fixtures from other independent operators and Gray Drug, the former Ohio-based chain, that helped him rebuild his practice.

It was lucky that he did receive help because obtaining insurance funds and government loans to rebuild and restock his store was a much more arduous and time-consuming task.

Nichol, who now divides his time between his South Park Pharmacy and his role as director of professional affairs for the nation's newest pharmacy school — the Southeastern College of Pharmacy — says there are several things the devastated pharmacists of St. Croix need to have happen to get their practices back in business:

One, they must quickly get insurance and reasonably-priced government loans to help them rebuild and restock. They also need to work with the drug companies to obtain insurance money the companies have available for inventories destroyed by the hurricane. Finally, they need the help of other pharmacists who have equipment and fixtures to donate to the relief effort. He himself is sending a showcase. He points out that the gifts are tax deductible.

Tax deductions nothwithstanding, Nichol says: "There is the need to do something. This is a humanitarian effort." He points out that it's not only the pharmacists' businesses that are at stake; it is also the lives of customers, such as diabetics, who rely on the pharmacies for their life-giving medicines.

Much of the help for the stricken pharmacies of St. Croix is being coordinated through the "Pharm Assist" Committee of the Dade County Pharmacy Association, which has the strong support of the Florida Pharmacy Association, NARD and the National Association of Wholesale Druggists.

Marvin Goldman, president of Miami-based Gulf Distribution and chairman of the association, writes: "The pharmacists of St. Croix, U.S. Virgin Islands, were almost destroyed by Hurricane Hugo. Their homes, their stores, the entire structure of the island was flattened, blown down by the terrible storm winds and rain."

The committee is working through the Virgin Island Action Relief Fund to collect the equipment, fixtures and computers needed to help the pharmacists reopen their stores, as well as clothing, toys, household articles and supplies for distribution to the families of pharmacists and the general population whose homes were demolished.

Marvin Goldman can be reached at (305) 634-6800, ext. 201.

Environment is part of the retail equation

THE HUMAN SIDE

AL HELLER

The nation's mood has swung so our environment might improve. Eat at McDonald's and signs urge you to sort recyclables from other trash. Soda bottle deposits threaten to reach 20 cents in some areas, and battery deposits have been proposed.

And when many Exxon customers canceled their credit cards after the Valdez oil spill in Alaska, business was put on notice that people are fed up and won't let companies act irresponsibly anymore.

Implications for retailers are clear. Deposits, recyclables, and new forms of products and packages could affect pricing, consumption trends and planograming. Merchants must add environmentally-safe strategies to the already complex equation of deciding what to sell and how to sell it.

In a way, Wal-Mart and K mart have begun. Indications are the retail drug trade may not be far behind.

Wal-Mart, the nation's third-largest retailer, challenged vendors in full page ads in *USA Today* and *The Wall Street Journal* to develop environmentally-sound merchandise in biodegradable or recyclable packaging. It read: "We're looking for quality products that are guaranteed not to last." Further, it plans to post shelf tags noting such manufacturer efforts.

K mart followed with ads in late September, which read: "Saving the future for tomorrow's generations . . . today!"

Moreover, K mart bags customer purchases in plastic bags that are recyclable, safe in landfills, printed with water-base ink, non-toxic when incinerated and meet Food and Drug Administration requirements.

For its part, Procter & Gamble is among packaged goods companies taking the lead in this effort. It hosted a seminar on Solid Waste Solutions in Cincinnati last month.

NACDS is preparing to tackle the solid waste issue head-on, when it hosts its first Distribution Conference Feb. 11-13, 1990, at Innisbrook Resort, Tarpon Springs, Fla. Ted Peterson, vp-trade relations, told me, "we are sensitive to the issue, and think this will be our most involved audience."

The NACDS Distribution Committee, formed in June to evaluate this and other issues, includes suppliers Bindley Western, Chesebrough-Pond's, Procter & Gamble, Burroughs Wellcome, Revlon and Eveready. Retailers include Peoples, Thrift, Supermarkets General, Chateau Drug and Surgical, Eckerd and Genovese.

Chain involvement is already surfacing. Rite Aid, for example, is about to begin merchandising private label trash bags that are degradable. Of course, private label is the area where retailers can exercise direct influence, since products and packaging are made to their specifications.

At Eckerd, vp Mike Zagorac said we are seeing business in its "infancy" of being environmentally responsible, and he expects to see real developments over the next two to three years. "There's not much out there yet in private label packaging that addresses these concerns, though we're looking at it," he told me.

"Having a safe and clean environment is certainly part of our role. We are high profile in health care, and the environment is part of that," Zagorac said. "Each time we take an action, customers see it as a positive. They send us letters, tell our store people."

He felt overall that if degradable packaging costs another dime or so, people would be willing to pay.

Similarly, Eli Cohen, president of Duane Reade, said: "No question we'd push for environmentally-safe products, even if it cost more. This is a very important project. Consumers would appreciate it.

"Whether for safety's sake or the environment, drug chains have been involved in lots of changes over the years — Tylenol seals, ozone sprays — and we ought to just step right into this."

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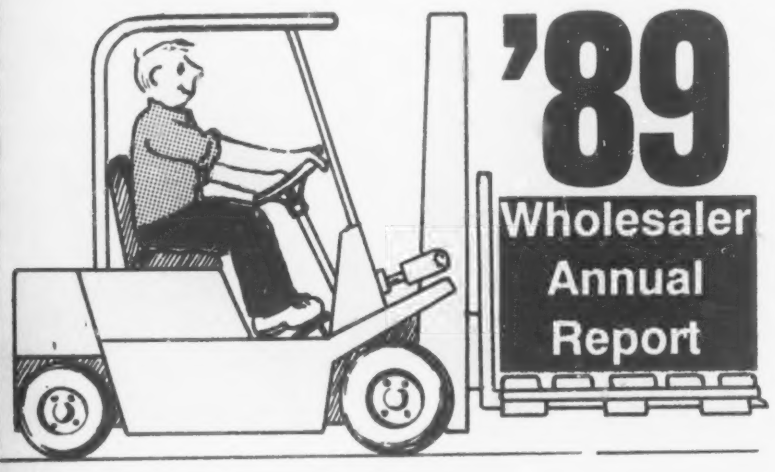
As margins slim, drug wholesalers beat 'value' drum

By Elizabeth Parks

Drug wholesalers had a good 1988 and most are reporting a fairly strong 1989, despite competitive pressures which continue to drag gross margins.

Nearly all major companies are reaping the benefits of onsolidation and technological gains. For the first time, he industry brought its total operating expenses below 5 percent.



Declining gross margins continue to be a challenge. Citing his group's latest Operations Survey, Barry Krelitz, National Wholesale Druggists Association (NWDA) chairman, notes hat despite an easing of the decline, margins *are still lown.* In 1988, the margin figure dropped 0.26 points to .34 percent, compared to an approximate 10-percent level in the early '80s.

Some wholesalers are disappointed in this latest erosion f margins, while other wholesalers are encouraged that the

Continued on page IP19

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Rx boards pumped up over steroid abuse

By Elizabeth Richardson

When Canadian sprinter Ben Johnson was stripped of his Olympic gold medal in 1988 after testing positive for the steroid stanozolol, the sports world was stunned. While many thought the Ben Johnson incident was just an isolated case of drug abuse, recent investigations into the use of steroids by athletes, particularly body builders using anabolic steroids, have uncovered widespread abuses that could have serious consequences for retail pharmacists and other practitioners who are in a position to dispense such potent medications.

The desire to win is causing some to lose when it comes to anabolic steroids. It's more than the athletes like Ben Johnson who are losing. Practitioners, who are illegally distributing these drugs, run the risk of losing their licenses for their activities.

Although anabolic steroids were introduced some 30 years ago —

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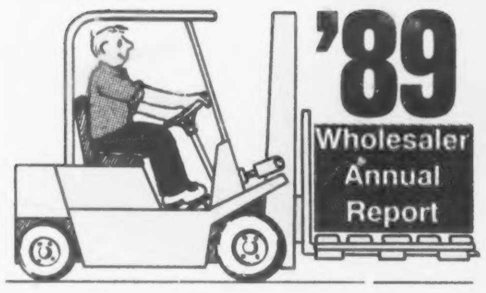
Value-added strategies shape wholesaler 'partnerships'



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decline wasn't worse.

Some sources, like Joe Polastri at McKesson, Mike Quinn at Cardinal and Burt Olin at Humiston-Keeling, still think the price/value relationship between wholesalers and their customers/suppliers is "out of sync." One source said emphatically that wholesalers are "giving much more than we're getting".

Polastri said he thinks the erosion means that wholesalers are still caught up in the competitive fight for market share, and that as long as this continues, margins will not substantially improve; indeed, he believes they may continue to decline.

Others said, however, they think the easing of the decline might signal a turnabout in fortunes.

Their feeling is that competition has eased off somewhat, at least in some markets and for some types of businesses, particularly hospital customers.

These sources said they think the margin erosion has "bottomed out" and that while margins probably will never get much higher than they are now, they will not show any more major dips either.

Some wholesalers said they think the scramble to lock in hospital contract business has peaked. That scramble to buy into a business that could add millions of dollars to revenues just by signing one contract is heavily blamed for precipitating the margin erosion trend.

"It is always expensive to bring in new business," one source said. Many companies have worked through the difficult phase of assimilating new customers and acquisitions, consequently, the pressure on gross margins may let up.

"Our business will continue to be price sensitive,"said Alco president and ceo John McNamara, "but price will be paramount only as long as everything else is equal. The more service we can offer our customers and the more we can comply with the manufacturer's needs to complete the cycle of bringing his products to the marketplace efficiently, the more we'll be in a position to enhance our margins because we will have more programs of value to offer everyone."

The average drug wholesaler distribution center now stocks approximately 29,000 SKUs.

'Value-added services will help us hold the line on margins, and may even help increase [them] in small ways.'
— Don Meyers, president, Harris Wholesale

"We haven't felt the pressures on margins we've felt in years before," said Don Meyers, the new president at Harris Wholesale. "Value-added services will help us hold the line on margins and they may even help increase [them] in small ways."

Cost efficiencies

This year, many wholesalers were also very encouraged by how much their companies have been able to save through operations expense reduction programs.

At the same time gross margins eased their decline, the industry was able to drop operations expenses to an all-time low, 4.99 percent, according to the NWDA Operations Survey.

Also another key profitability index, asset turnover, also achieved what NWDA believes is another all-time high.

In 1988, asset turnover was up to 4.15 times, its highest rate since NWDA began tracking it in 1981.

Many wholesalers are also optimistic about the industry's continuing ability to lower its costs of doing business, primarily because of a growing commitment to electronic data interchange (EDI) and bar coding.

EDI could have a tremendous impact on profits. Mel Whitmire, Amfac president, says he's heard about a grocery wholesaler who was able to save $10,000 a day once his EDI program was fully implemented.

"I don't know if the wholesale drug industry could do as well," he says, "but there seems to be a lot of promise in this area. It will probably take four to five years for everyone to get implemented."

There are still many companies who can profit further from consolidating smaller facilities into larger houses and from modernizing and upgrading their facilities with computerized equipment.

Value-added services

Wholesalers may soon be able to enhance their margins through the expansion of value-added programs, including more and better marketing programs for their retail customers, asset management programs and "customized" computer programs for hospital clients.

In fact, many wholesalers this year seemed to be evolving into financial and marketing partners with their customers and suppliers.

Many wholesalers described themselves less as "distributors of product" and more as "specialists" whose strategic mission is to help their partners, both customers and suppliers, improve the management of their businesses.

Some sources said they see themselves playing several roles, the most basic being distributors of product into the marketplace. For example, Alco's McNamara described his company as being an "extension of sales and marketing for manufacturers" as well as a "partner to retailers and hospitals."

Bob Walter and Mike Quinn at Cardinal, Bob Anderson at Owens, Roman Englander at Drug Guild, Burt Olin at Humiston, Fred Toney at McKesson, Bob King at Fox-Meyer, Phil Engle at Bergen, Bill Bindley at Bindley Western and others all made similar points.

More than ever before, wholesalers today are looking at their customer mix and responding to the diversity there by organizing their customers by "areas of specialization" (as Bob Anderson put it), who have to be serviced according to their different needs.

Good examples are marketing programs developed for large chains that would not suit the needs of smaller regional chains. Or, developing services tailored to independents operating "full-line stores" with heavy front-end merchandising, and different programs for independents who operate smaller stores specializing in prescriptions and a small selection of over-the-counter products.

A new area being developed by some wholesalers is providing value-added services to hospitals, services that are meant to develop "long-term" relationships just as they do with retail customers.

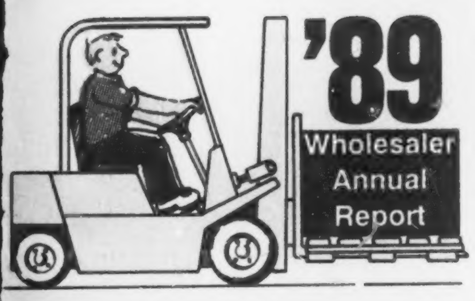
Many wholesalers predict that in addition to creating stronger loyalties between their companies and hospitals, value-added services will contribute positively to gross margin. Wholesalers reason that hospitals, like retailers, will pay more for services that help them manage their assets, control turns, and achieve an overall higher return on investment.

Some wholesalers are even starting to talk about "asset management" for both hospital and retail customers as a key part of their strategy.

Bob Anderson, senior vp-group development, Owens & Minor, puts it this way: "We say price is a function between manufacturer and user. We provide the functions that are necessary in order to have an efficient movement between the manufacturers and the users. Our functions and systems enable us to specialize in their businesses, and make us valuable as partners."

DRUG STORE NEWS
INSIDE
PHARMACY
PHARMACIST EDITION

Profile of an average drug wholesaler: 1989



Methodology

- The survey was mailed to the 68 corporations who are members of the National Wholesale Druggists' Association in late summer. Thirty-four percent of NWDA's members responded to the survey.

Customer mix

- 44% are deliveries to independents;
- 22% are to chain stores;
- 6% are to chain warehouses;
- 4% are to mass merchandisers and food stores;
- 0.85% are to HMOs, PPOs, nursing homes and nursing home suppliers,
- 23% are to hospitals

Perceived growth areas for the next two years:

- 91% of our respondents said sales will increase from independents
- 76% from hospitals buying pharmaceuticals
- 67% from chain drug stores
- 65% from food, grocery and combination food/drug stores
- 63% home health care retailers
- 58% from mass merchandisers
- 55% from nursing home suppliers
- 47% from deliveries to mail order houses
- 44% from hospitals for OTC products
- 47% from HMOs
- 41% from independent retail buying groups
- 40% from deliveries to chain warehouses
- 39% from deliveries to clinics
- 24% from hospitals buying medical/surgical supplies
- 17% from PPOs including PSAOs
- 11% from nursing homes direct
- 6% from physicians or corporations with their own formularies

Future of value-added services

- 90% point-of-purchase aids
- 86% promotional and advertising support programs
- 86% scanning software
- 83% said they will be doing more merchandising/marketing support
- 80% point-of-sale (POS) software
- 77% planograms
- 77% co-op ad dollar programs
- 75% POS scanning/computer hardware
- 67% host support for computers
- 64% product movement reports
- 65% private label programs
- 61% helping customers bid on managed health care business
- 59% price updates
- 55% arranging financing with third parties such as banks
- 50% shelf price labels
- 50% pharmacy system software
- 50% pharmacy computer hardware
- 50% inventory reports
- 53% store remodeling programs
- 53% financial management reports
- 39% help with site selection
- 37% acquisitions or new stores
- 35% store fixture programs
- 31% third-party claim processing
- 27% product price labels
- 27% extended dating on opening inventories
- 27% direct loan for expansion
- 25% business insurance
- 13% accounting, bookkeeping services
- 7% co-signing loans for retailers

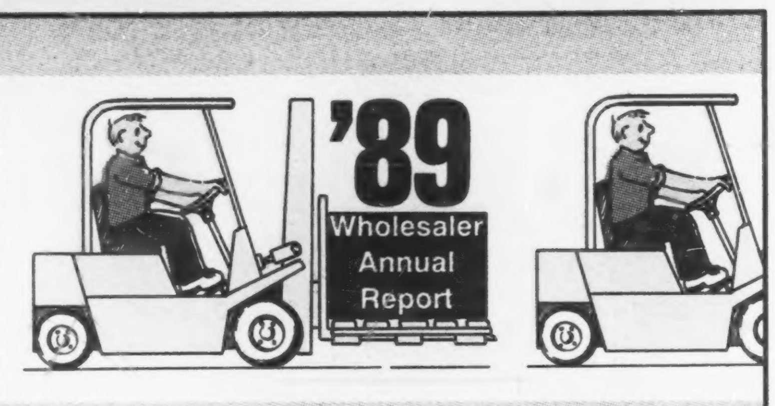
Current product mix

- 80% of sales are for prescription products
- 10% OTC
- 6% H&BA
- 1% Home Health Care (convalescent aids and durable medical equipment)
- 2% other

Current terms of sale

- 52% of all wholesalers ask their customers to pay within 15 days of delivery
- 10% give a 2% discount to those who do pay in 15 days
- 48% say they have a variety of payment terms, ranging from pre-pay before delivery to twice a month payment plans, to net discounts for customers who pay on select days of the month such as the 10th and 25th.

The nation's 35 highest volume drug wholesalers



Company	FY ended	Estimated sales most recent FY (Millions of $)	Sales projections for next FY (Millions of $)
1. McKesson Drug San Francisco	3/31/89	$5,800	$6,340 (est.)
2. Bergen Brunswig Los Angeles	8/31/89	3,800	4,250 (est.)
3. FoxMeyer Denver	3/31/89	2,100	2,200 (est.)
4. Alco Health Services Valley Forge, PA	9/30/88	2,100	2,300 (est.)
5. Bindley Western Indianapolis	12/31/88	1,300	1,600 (est.)
Total sales of top 5: $15.1 billion			
6. Harris Wholesale Solon, OH	10/31/88	1,000	1,200 (est.)
7. Amfac Folsom, CA.	6/30/89	946	1,200 (est.)
8. Cardinal Health Dublin, OH	3/31/89	700	900 (est.)
9. Humiston-Keeling Chicago	4/30/89	464	510 (est.)
10. Durr Fillauer Montogomery, AL	12/31/88	387	491 (est.)
Total sales of top 10: $18.6 billion			
11. Moore Medical Corp. New Britain, CT	12/31/88	235	250 (est.)
12. Ketchum & Co. Clark, NJ	9/30/88	231	255 (est.)
13. Owens & Minor Richmond, VA	12/31/88	231	255 (est.)
14. Drug Guild Distributors Secaucus, NJ	7/31/89	220	250 (est.)
15. Commons Bros., Inc. Elmsford, NJ	4/30/88	220	280 (est.)
Total Sales of top 15: $19.7 billion			
16. Kay Wholesaler Drug Co. Wilkes-Barre, PA	6/30/89	186	220 (est.)
17. Walker Drug Birmingham, AL	12/31/88	180	190 (est.)
18. Newman Wholesalers Ridgefield, NJ	4/30/89	178	220 (est.)
19. Tennessee Wholesale Drug Nashville, TN	3/31/89	170 (est.)	180 (est.)
20. Chapman Drug Co. Knoxville, TN	6/24/89	167	196
Total estimated sales of top 20: $20.6 billion			
21. Gulf Distribution, Inc. Miami, FL	6/30/89	166	191 (est.)
22. Twin City Wholesale Drug Minneapolis	4/30/89	165	185 (est.)
23. Behrens, Inc. Waco, TX	12/31/88	160 (est.)	170 (est.)
24. North Carolina Mutual Wholesale Drug Durham, NC	3/31/89	145	160 (est.)
25. The F. Dohmen Co. Germantown, WI	4/30/89	136 (est.)	150 (est.)
Total estimated sales of top 25: $21.4 billion			
26. J.E. Gould & Co. Portland, ME	12/31/88	119 (est.)	137 (est.)
27. Solomons Co. Savannah, GA	8/31/88	110 (est.)	127 (est.)
28. James Brudnick Co. Malden, MA	12/31/88	110	127 (est.)
29. D.T.C. Smith Co. Asheville, NC	4/30/89	105 (est.)	120 (est.)
30. Remo Drug Brooklyn, NY	12/31/88	100	105 (est.)
Total estimated sales top 30: $21.9 billion			
31. South Bend Drug South Bend, IN	12/31/88	88	112 (est.)
32. Dik Drug Burr Ridge, IL	12/31/88	85 (est.)	90 (est.)
33. Northwestern Drug Minneapolis	12/31/88	72	82 (est.)
34. Miami-Luken, Inc. Dayton, OH	6/30/88	65	75 (est.)
35. Value Drug Altoona, PA	12/31/88	65	76 (est.)

Total estimated sales for top 35: $22.3 billion
Total estimated 1989 sales for industry: $25.3 billion
Top 35 share of total (est.) 1989 industry sales: 88.1%

Note: Louis Zahn Co., Melrose Park, Ill., was acquired this year by FoxMeyer. In FY '88, Zahn had sales of $216 million. Northwestern Drug, Auburn, Wash., was acquired by Amfac Health Services. In FY '88, Northwestern had sales of $180 million.

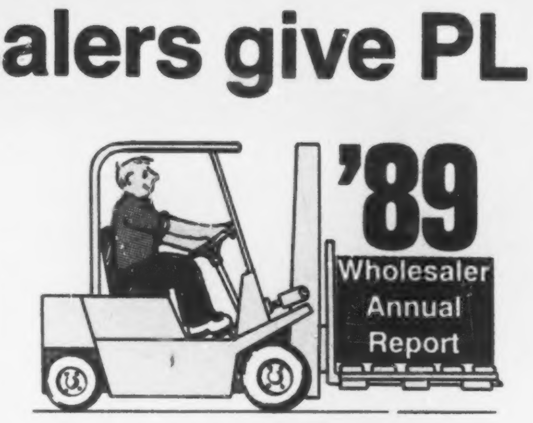
Source: *Drug Store News*/NWDA Survey

Pharmaceuticals currently account for about 80 percent of the average wholesale drug company's sales, according to this year's DRSN/NWDA survey.

Drug wholesalers give PL more weight

Private label vitamin, OTC and H&BA programs continued to grow in importance over the past year, as did generic source programs which many wholesalers have added to their regimen of "value added services."

In almost all cases, private label programs are growing substantially. Some companies, like McKesson, now carry over 300 private label items. However, this year's inquiry by the Food and Drug Administration (FDA) on the safety and quality of some generic prescription brands has caused most wholesalers to be more cautious about choosing generic suppliers.



John McNamara, Alco's president, said that as a wholesaler, he'd be selectiv in choosing generic suppliers buying only from companie "with a good track record. Another wholesaler saw th investigation as an opportunity to "drop some dead lines."

Home Health Care

Home health care is no growing as dramatically a some wholesalers expected According to NWDA, hom health care as a percent of total wholesaler sales is down b 0.1 points this year, and som wholesalers say this may b because home health care ha turned out to be too expensiv an investment and too hard category for the average independent retailer.

Durable medical equipmen (DME) is especially hard t handle as an investment. It involves tying up inventory dollars with slower turns tha don't justify the investment Some wholesalers say th "jury is still out" on the futur of DME and home health car in general as appropriat products for the averag wholesaler's product mix.

Medical/surgical sales, o the other hand, have a lot o promise. Some wholesalers lik Owens and Minor have alway done a strong medical and surgical business. More recently Harris Wholesaler's is trying t develop a "synergistic" marketing program that would allow i to combine sales and marketing efforts with its sister division General Medical Corp., the second largest distributor of medical and surgical supplies in th nation.

Acquisitions

There has not been as much acquisition activity in the pas year as the industry's seen i previous years, but FoxMeyer and Amfac have mad two important acquisitions.

Chicago-based Louis Zahn is merging with FoxMeyer and Auburn and Washington-based Northwestern Drug is being acquired by Amfac. Ohio-based Miami Luken, which did approximately $65 million in sales for its 1988 fiscal year, acquired a small independent in its area, Cincinnati-based Hale-Justis, which did about $20 million in sales last year.

Most sources expect the acquisition front will be quiet for a while. For one thing, the Federal Trade Commission is scrutinizing possible acquisitions to make certain that monopolies don't develop, and some companies at this point are too highly leveraged to take on any new projects.

A NEW CHOICE
FOR PEDIATRIC CARE
Children's
Advil®
(ibuprofen)
Suspension
100mg/5mL

BRIEF SUMMARY OF PRESCRIBING INFORMATION
CONTRAINDICATIONS: Patients hypersensitive to ibuprofen or patients with all or part of the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions to ibuprofen have occurred in such patients.
WARNINGS: Risk of GI Ulcerations, Bleeding, and Perforation with NSAID Therapy: Physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDS even in the absence of previous GI tract symptoms. In patients observed in clinical trials of several months' to two years' duration, symptomatic upper GI ulcers, gross bleeding or perforation appear to occur in approximately 1% of patients treated for 3-6 months, and in about 2-4% of patients treated for one year.
Except for a prior history of serious GI events and other risk factors known to be associated with peptic ulcer disease, no risk factors have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals and most spontaneous reports of fatal GI events are in this population.
PRECAUTIONS: General: Because serious GI tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding.
Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If a patient develops such complaints the drug should be discontinued and the patient should have an ophthalmologic examination.
Fluid retention and edema have been reported with ibuprofen; therefore, the drug should be used with caution in patients with a history of cardiac decompensation or hypertension.
Ibuprofen can inhibit platelet aggregation and prolong bleeding time. CHILDREN'S ADVIL® SUSPENSION should be used with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.
The antipyretic and anti-inflammatory activity of ibuprofen may reduce fever and inflammation, thus diminishing their utility as diagnostic signs in detecting complications of presumed noninfectious, noninflammatory painful conditions.
Small decreases (usually not exceeding one gram) in hemoglobin and hematocrit with an apparent dose response relationship have been observed following chronic administration. If there are no signs of bleeding, it is probably not clinically important.
To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have their therapy tapered slowly when CHILDREN'S ADVIL® SUSPENSION is added to the treatment program.
Aseptic meningitis: Aseptic meningitis with fever and coma has been observed on rare occasions in adult patients on ibuprofen therapy. Although it is more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in adult patients who do not have underlying chronic disease. If signs or symptoms of meningitis develop in a patient on CHILDREN'S ADVIL® SUSPENSION, the possibility of its being related to ibuprofen should be considered.
Renal Effects: As with other nonsteroidal anti-inflammatory drugs, long-term administration of ibuprofen to animals has resulted in renal papillary necrosis and other abnormal renal pathology. In humans, there have been reports of acute interstitial nephritis with hematuria, proteinuria, and occasionally nephrotic syndrome.
A second form of renal toxicity has been seen in patients with prerenal conditions leading to reduction in renal blood flow or blood volume. In these patients, administration of a nonsteroidal anti-inflammatory drug may cause a dose dependent reduction in prostaglandin formation and precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, and those taking diuretics and the elderly. Those patients at high risk who chronically take CHILDREN'S ADVIL® SUSPENSION should have renal function monitored if they have signs or symptoms of azotemia. Discontinuation of nonsteroidal anti-inflammatory drug therapy is typically followed by recovery to the pretreatment state.
Since ibuprofen is eliminated primarily by the kidneys, patients with significantly impaired renal function should be closely monitored and a reduction in dosage should be anticipated to avoid drug accumulation.
Information for Patients: Physicians may wish to discuss with their patients the potential risks and likely benefits of treatment with CHILDREN'S ADVIL® SUSPENSION.
Laboratory Tests: Meaningful (3 times the upper limit of normal) elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. A patient with symptoms and/or signs suggesting liver dysfunction, or in whom an abnormal liver test has occurred, should be evaluated for evidence of the development of more severe hepatic reactions while on therapy with ibuprofen. If abnormal liver tests persist or worsen, if clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur, CHILDREN'S ADVIL® SUSPENSION should be discontinued.
Diabetes: Each 5 mL of CHILDREN'S ADVIL® SUSPENSION contains 2.5 g of sucrose which should be taken into consideration when treating patients with impaired glucose tolerance. It also contains 350 mg of sorbitol per 5 mL. Although in clinical trials CHILDREN'S ADVIL® SUSPENSION was not associated with more diarrhea than control treatments, should a patient develop diarrhea, the physician may wish to review the patient's dietary intake of sorbitol from other sources.
Drug Interactions: *Coumarin-type Anticoagulants:* Bleeding has been reported when ibuprofen and other nonsteroidal anti-inflammatory agents have been administered to patients on coumarin-type anticoagulants; the physician should be cautious when administering CHILDREN'S ADVIL® SUSPENSION to patients on anticoagulants.
Aspirin: Concurrent use of aspirin is not recommended.
Methotrexate: In vitro studies indicate that ibuprofen could enhance the toxicity of methotrexate. Caution should be used if CHILDREN'S ADVIL® SUSPENSION is administered concomitantly with methotrexate.
H_2 Antagonists: In studies with human volunteers, coadministration of cimetidine or ranitidine with ibuprofen had no substantive effect on ibuprofen serum concentrations.
Furosemide: Ibuprofen can reduce the natriuretic effect of furosemide and thiazides in some patients. During concomitant therapy with CHILDREN'S ADVIL® SUSPENSION, the patient should be observed closely for signs of renal failure as well as to assure diuretic efficacy.
Lithium: Ibuprofen produced an elevation of plasma lithium levels (15%) and a reduction in renal lithium clearance (19%) in a study of 11 normal volunteers during the period of concomitant drug administration. Patients should be observed carefully for signs of lithium toxicity. Read package insert for lithium before its use.
Pregnancy: Administration of ibuprofen is not recommended during pregnancy or for use by nursing mothers.
Infants: Safety and efficacy of CHILDREN'S ADVIL® SUSPENSION in children below the age of 12 months have not been established.
ADVERSE REACTIONS: The most frequent type of adverse reaction occurring with CHILDREN'S ADVIL® SUSPENSION is gastrointestinal. In clinical trials among adults involving chronic administration of ibuprofen, the percentage of patients reporting one or more gastrointestinal complaints ranged from 4% to 16%.
Incidence Greater Than 1% (but less than 3%), Probable Causal Relationship
Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence).
Central Nervous System: Dizziness,* headache, nervousness.
Dermatologic: Rash (including maculopapular type),* pruritus.
Special Senses: Tinnitus.
Metabolic/Endocrine: Decreased appetite.
Cardiovascular: Edema, fluid retention (generally responds promptly to drug discontinuation) (see PRECAUTIONS).
*Reactions occurring in 3% to 9% of adult patients treated with ibuprofen.
Precise Incidence Unknown (but less than 1%), Probable Causal Relationship
Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, pancreatitis, melena, gastritis, hepatitis, jaundice, abnormal liver function tests.
Dermatologic: Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia.
Central Nervous System: Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma.
Special Senses: Hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS).
Hematologic: Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit (see PRECAUTIONS).
Cardiovascular: Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations.
Allergic: Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS).
Renal: Acute renal failure in patients with preexisting significantly impaired renal function (see PRECAUTIONS), decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria.
Miscellaneous: Dry eyes and mouth, gingival ulcers, rhinitis.
Precise Incidence Unknown (but less than 1%), Causal Relationship Unknown
Central Nervous System: Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri.
Dermatologic: Toxic epidermal necrolysis, photoallergic skin reactions.
Special Senses: Conjunctivitis, diplopia, optic neuritis, cataracts.
Hematologic: Bleeding episodes (eg, epistaxis, menorrhagia).
Metabolic/Endocrine: Gynecomastia, hypoglycemic reactions, acidosis.
Cardiovascular: Arrhythmias (sinus tachycardia, sinus bradycardia).
Allergic: Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis, angioedema.
Renal: Renal papillary necrosis.
OVERDOSAGE: Patients with a history of ingestion of greater than 100 mg/kg should have induced emesis or gastric lavage. Multiple dose oral administration of activated charcoal may be useful. Supportive therapy may include oxygen, respiratory support, and parenteral fluids. Because the drug is acidic and excreted in the urine, administration of sodium bicarbonate and induction of diuresis may be beneficial.
DOSAGE AND ADMINISTRATION: Juvenile arthritis: 30-40 mg/kg day in 3 or 4 divided doses
Fever: 5 mg/kg if baseline temperature is 102.5°F or below or 10 mg/kg if baseline temperature is greater than 102.5°F every 6-8 hours (children); 400 mg every 4-6 hours (adults)
RA and OA: 1200-3200 mg per day in 3 or 4 divided doses
Mild to moderate pain in adults: 400 mg every 4 to 6 hours
Dysmenorrhea: 400 mg every 4 hours
HOW SUPPLIED: 4 and 16 oz. bottles
Caution: Federal law prohibits dispensing without prescription.

References:
1. Walson PD, Galletta G, Braden NJ, Alexander L. Ibuprofen, acetaminophen, and placebo treatment of febrile children. *Clin Pharmacol Ther.* 1989;46:9-17.
2. Independent Clinical Study: Reduction of Fever in Children, Multiple Dose. Data on file, Medical Department, Whitehall Laboratories.
3. Independent Clinical Study: Juvenile Arthritis. Data on file, Medical Department, Whitehall Laboratories.

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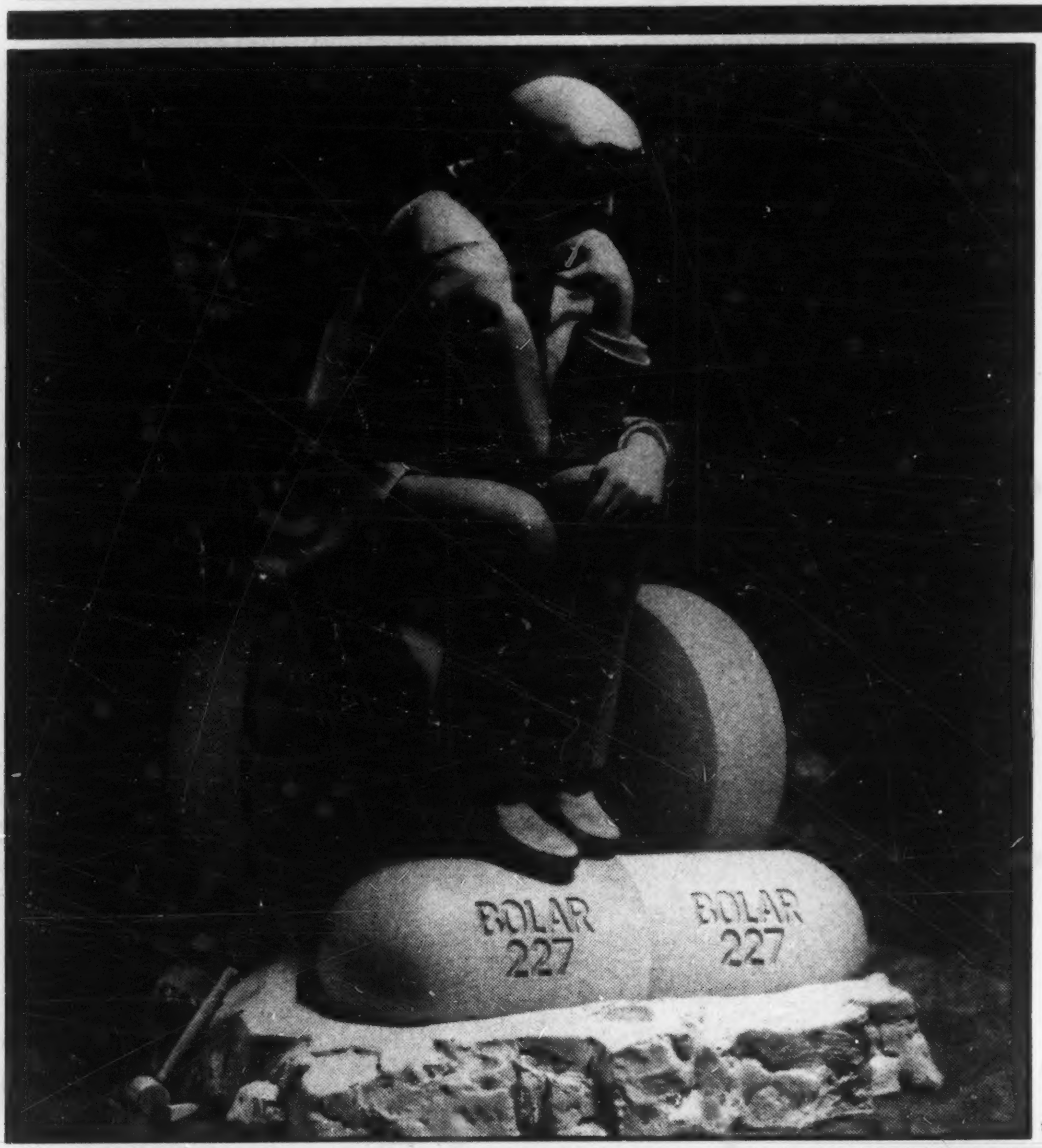

Think

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Wholesaler expansion primarily internal

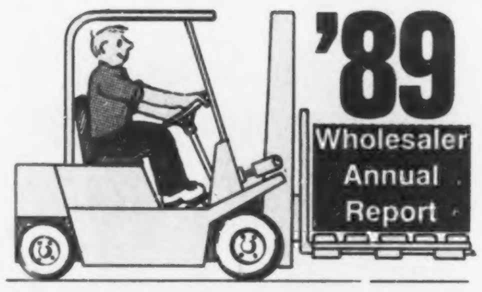
Expansion is still underway in the wholesale industry, but it is happening internally. Wholesalers enter new markets or beef up their presence in existing markets by building bigger, larger and more sophisticated facilities.

Florida, Texas, New Jersey and New England were particularly mentioned as attractive markets to get more involved in.

This is still an industry very much dominated by the highest-volume companies. In 1989, for example, the top five companies will generate over $15 billion in sales, approximately 60 percent of the $25 billion it is estimated the industry will do in 1989. The top 10 companies will generate 74 percent of total sales.

The companies in the second tier, those doing between $150 million and $500 million in sales, are depending on their flexibility and creativity to survive and prosper. Most of these companies are working hard to create a "service centered business" in which they treat their customers' needs as their own, and their suppliers needs as the needs of a partner.

The bigger companies are trying to do this as well, but the middle level chains are betting that their size, protecting them from the danger of bureaucratic stiffness, will give them a competitive edge.

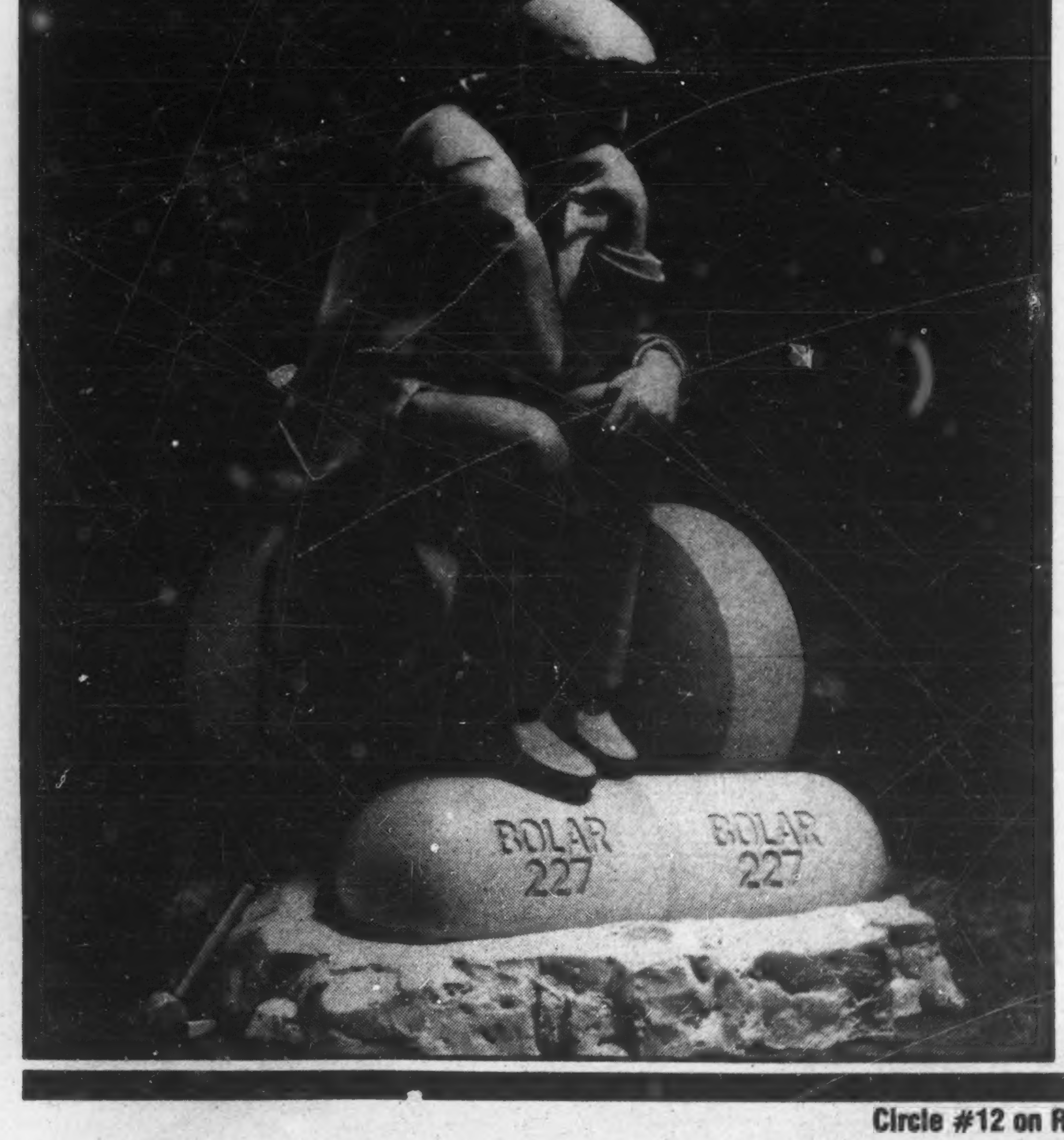


Drug wholesalers: five-year sales growth

(In billions of $)

	1984	1985	1986	1987	1988	1989 (est.)
Dollar sales	$12.5	$14.0	$16.6	$19.4	$22.2	$25.2
Percentage change vs. prior year (current dollars)	12.8%	14.8%	18.5%	16.8%	14.0%	14.0%
Percentage change adjusted for price changes/ inflation	4.8%	8.7%	12.6%	9.4%	9.5%	N.A.

Source: NWDA 1988 Operating Survey/*Drug Store News* 1989 sales estimates



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Profile: McK keeps a strong focus on service

SAN FRANCISCO — McKesson Drug is continuing to evolve into a service-oriented wholesaler with a strong emphasis on value-added programs for their retail customers.

To that end, the San Francisco-based wholesaler introduced an in-store training program, a cholesterol testing program and a brand new national Valu-Rite cable television ad campaign that is breaking this month.

They have also enhanced their pharmacy design department by adding a computer-aided design program to their system.

Fred Toney, McKesson's senior vp-sales and merchandising, said the program lets McKesson develop a much better, more accessible design for its customers. When a retailer wants to redesign his store, a McKesson sales rep can take his store's individual measurements, send them down to the computer and have the computer generate and print out the new layout.

McKesson is also adopting a new value-added system for its hospital customers. President Joe Polastri said its new hospital program, which will be launched early next year, will be "the best system out there. No one has what we have." It will be a PC-based system that will allow hospitals access to the McKesson mainframe to get data on such things as ordering, pricing, product availability, and substitutions.

In the technological area, McKesson is continuing to test a new system to monitor materials handling. The system they are working with is called Flex Master; it's been used in the Sacramento warehouse for a year now. Polastri says the test is working out "pretty well, but it is too early to talk about savings or expansions."

To operate more efficiently, the company is continuing to close smaller distribution centers and consolidate into bigger facilities that can operate more efficiently.

This year, McKesson opened four new facilities in Salt Lake City, Oklahoma City, Tampa and Cincinnati. It started the year with 48 facilities in operation and ended with 47. But the 47 facilities were doing an average of $120 million per year. In contrast, some smaller and mid-size companies are generating volumes in the $50, $60 and $80 million a year range while others are averaging as low as $22 million per facility.

Continued on next page

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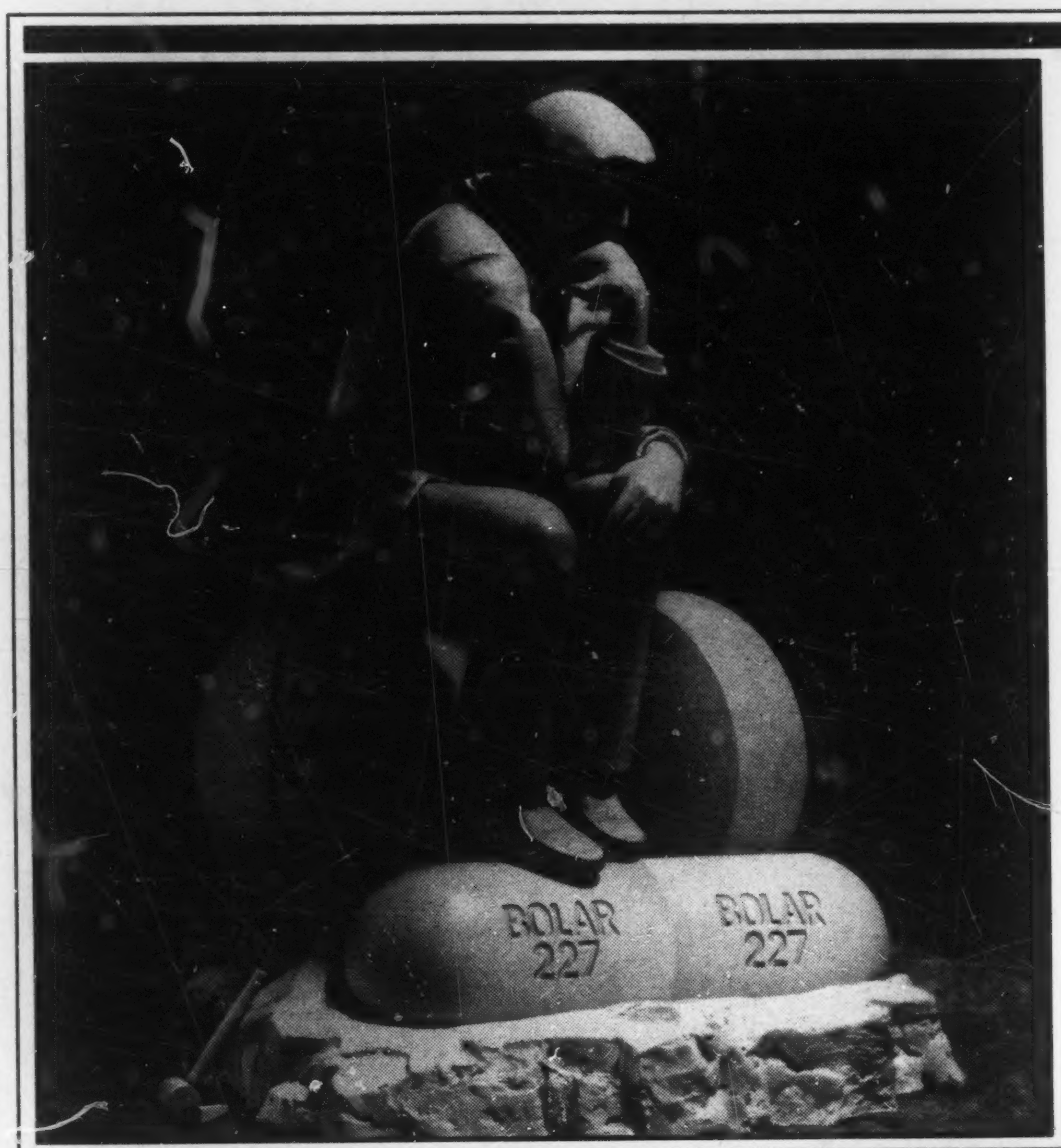
Today, McKesson operates vith 4.4 million square feet of varehouse space. The wholesaler also operates nationally nd can service accounts anywhere, a key factor Polastri ays helped it to win the Wal-Mart account: "The wholesaler hey had been using had to go a ong way to service them. We vere more efficient. We're in ll the markets that they're in, nd we're also in California and New England where they are planning to expand."

In the past year, McKesson has also increased the number of retailers in its Valu-Rite voluntary program. Valu-Rite now has over 3,000 members, or approximately 20 percent of all McKesson's retail accounts.

McKesson is expanding the mix in its private label programs, and giving more promotional support to private label brands. This year's trade show in July was its biggest ever. Toney says it had the largest turn-out in McKesson's history, and sales at the show exceeded $72 million.


Think Generics Think

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Profile: Bergen's strategy? 'Help stores make money'

ORANGE, Calif. — At Bergen Brunswig, Phil Engle, president, says the most important accomplishment last year was "a company-wide emphasis on quality improvements."

Engle says Bergen's strategic focus this year is to put together "a continuous, formulated quality improvement program involving everyone.

"Anything that impacts the quality of service, we're looking at," he says.

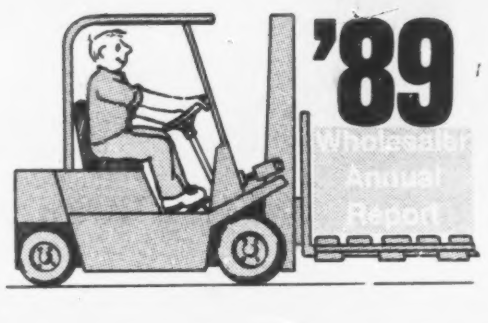
Like most wholesalers, Bergen is using advisory boards to point out areas needing improvement or enhancement. It currently has five such boards. "Ultimately the companies that grow and prosper in this industry," says Engle, "will be those that focus on their customers and their suppliers.

"The whole drug industry has pared itself down to where whatever little change can be made in price incentives is minimal, one-tenth or two-tenths of a percent basically.

"The savings that customers can realize from a difference of one- or two-tenths of a percent will be insignificant if their supplier can't deliver high-quality programs that will help them make or save money."

To further strengthen its position in the marketplace, Bergen is segmenting its customer base and developing marketing programs tailored to a diverse base of customers. Some of those customers include general drug stores, prescription drug stores, acute care hospitals, maintenance hospitals, and large and small chains.

One of its new value-added programs for hospitals is a complete on-line hospital computer system that can perform several vital functions, including ordering, inventory control, and price updates. Expected to be launched next month, the new system has been designed to save hospitals time and money, and improve health care service by helping to make them more efficient.



It is also supporting its Good Neighbor voluntary program with national television advertising that broke early last summer on cable television.

Bergen also has a fairly new customer analysis program for retailers.

In terms of technology, new automated systems installed in its Valencia warehouse when it opened more than a year ago are working out "very well," Engle says. It now plans to open a second warehouse like Valencia's in Corona, Calif., in August 1990.

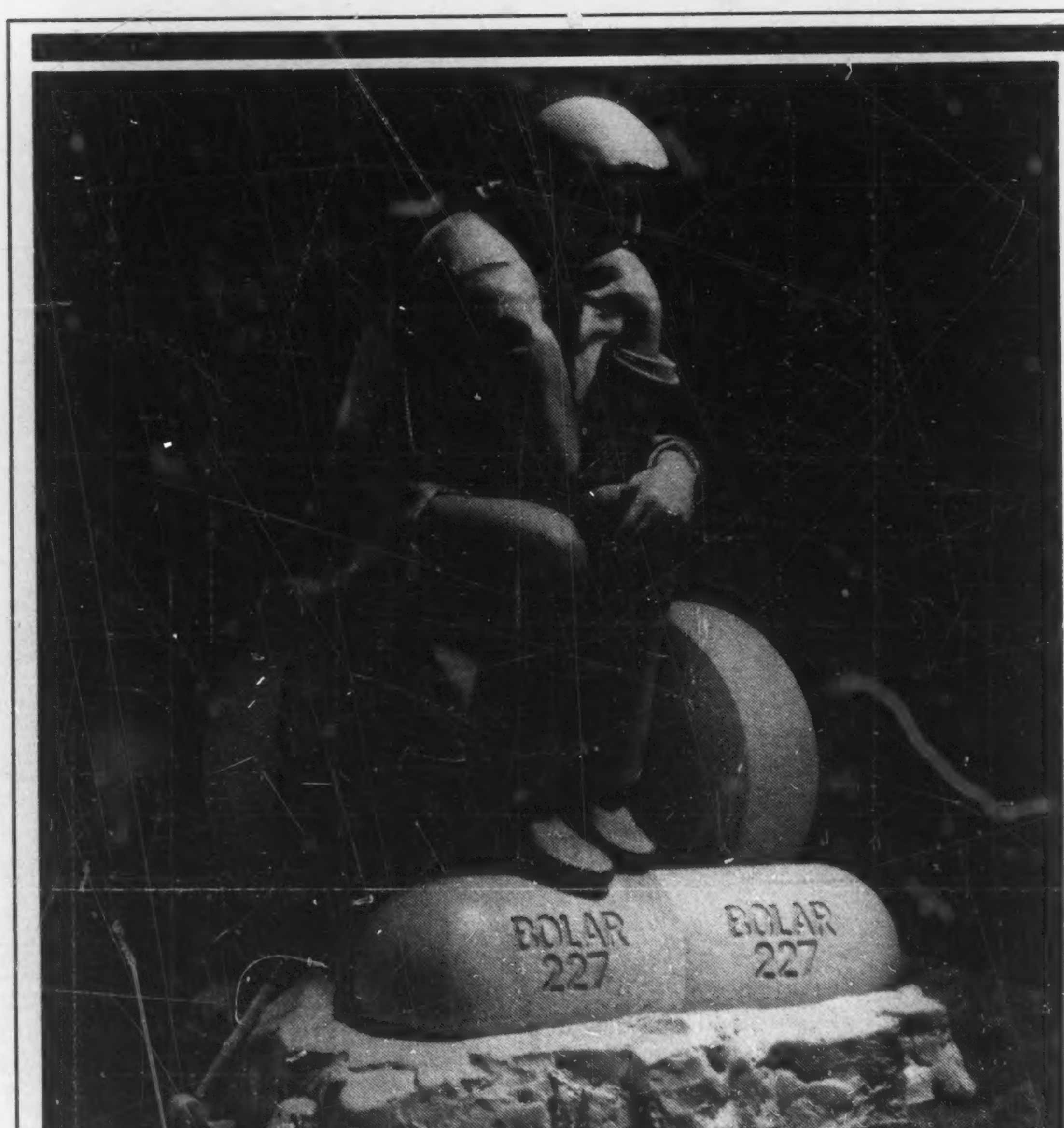
The Valencia facility currently has two 100-foot A-Frame automated pickers. Orders are electronically put on the conveyor belt and Custom Management System software moves the orders to wherever they need to go. The conveyor takes the product to the picker who picks it. It carries it over to where the tote is lidded and strapped and rolls it down to where workers are waiting to load it on the truck. The automated system covers about half the items that are picked in the warehouse, Engle says.

Drug wholesalers customer sales mix

(Percentage of drug wholesale gross sales)

Customers	1979	1985	1986	1987	1988
Independents	60.7%	50.0%	47.7%	45.6%	44.2%
Chain drug stores	20.8	23.2	23.7	22.8	21.7
Hospitals	11.4	19.5	20.1	22.2	22.8
Chain drug warehouses	4.7	4.2	5.1	5.0	6.1
Mass merchandisers, food stores	1.6	2.0	2.3	2.5	3.4
Clinics, nursing homes, others	0.8	1.2	1.2	1.9	0.9

Source: NWDA 1988 Operating Survey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Profile: FoxMeyer focuses on 'the drug side of business'

CARROLLTON, TEXAS — Last year was pretty much devoted to restructuring FoxMeyer, and "this year, FoxMeyer is going back to focusing on the drug side of its business," says Bob King, president.

In the coming months, FoxMeyer will finish consolidating its recently-acquired Louis Zahn division into its Carol Stream facility just outside Chicago. The larger facility has the capacity to do over $400 million a year while the two smaller facilities between them did about $350 million.

That consolidation should be completed by next March. FoxMeyer is also consolidating its smallest division in Wichita into Kansas City and Oklahoma City. That will bring the wholesaler down to 12 facilities, with the lowest-volume one generating $90 million annually "with growth potential," compared with $75 million now. "We should save $1 million just by closing Wichita," King said.

This past year, FoxMeyer made a series of key personnel changes, including hiring a chief financial officer, a senior vp of data processing and a senior vp of human resources for its Dallas division.

"We feel we have strong people who will give us what we need for the future," King said.

King also thinks that value-added services are particularly crucial to a wholesaler's future prosperity. FoxMeyer is continuing to sign up new members to the Health Mart voluntary program, adding 150 over the past year.

It has strengthened recruitment of independents, inviting potential customers "to come grow with us." That's garnered 500 new accounts over the past couple of years, King says.

Some incentives for attracting new customers have been quite creative. Their salespeople, for example, will send a potential customer a chocolate cream pie or an apple pie and with it, they'll enclose a message like "Grab a bigger slice of the pie. Come grow with us."

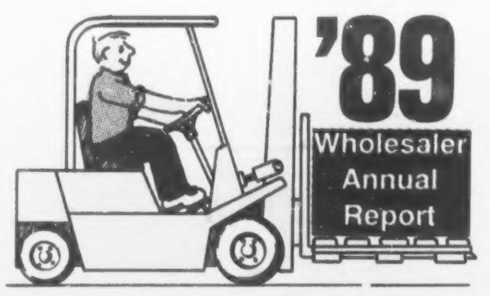
Or they may promise a brighter future and send that message along with a pair of sunglasses.

It also rolled out a new generic prescription distribution program called Direct Source. The program centers around FoxMeyer going directly to a generic manufacturer, eliminating the middleman, thereby cutting a better deal for the retail.

FoxMeyer is also testing a new home health care product catalog. "It's the most cost-efficient way for retailers to get into that business," King says.

Other technological advances include a new computer system for hospital customers. King describes it as a PC-based "sophisticated order processing/inventory control inquiry system." Hospitals can access the system to see exactly what's available at what price. FoxMeyer has done about 50 installations to date and is proceeding to install about 15 more each month.

It is one of the few wholesalers helping its retailers expand into the HMO market by bidding for an HMO and passing the contract to the retailer.

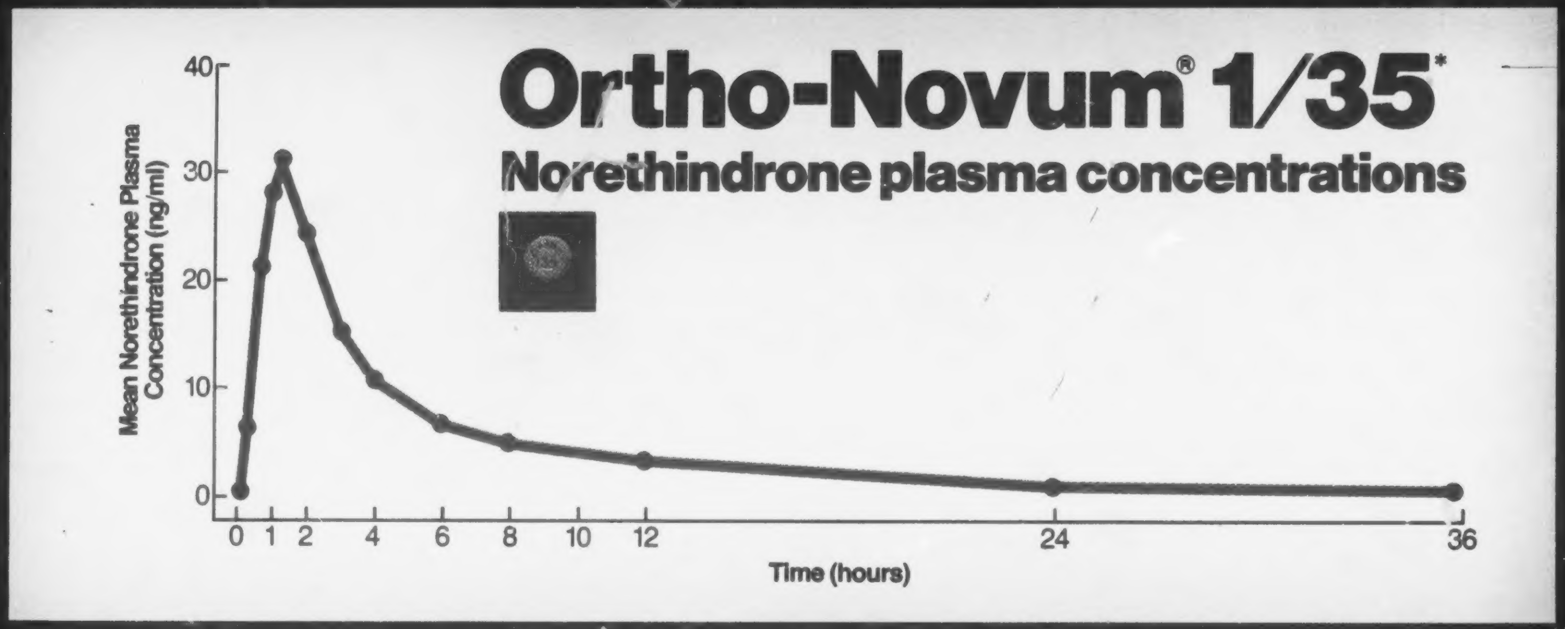


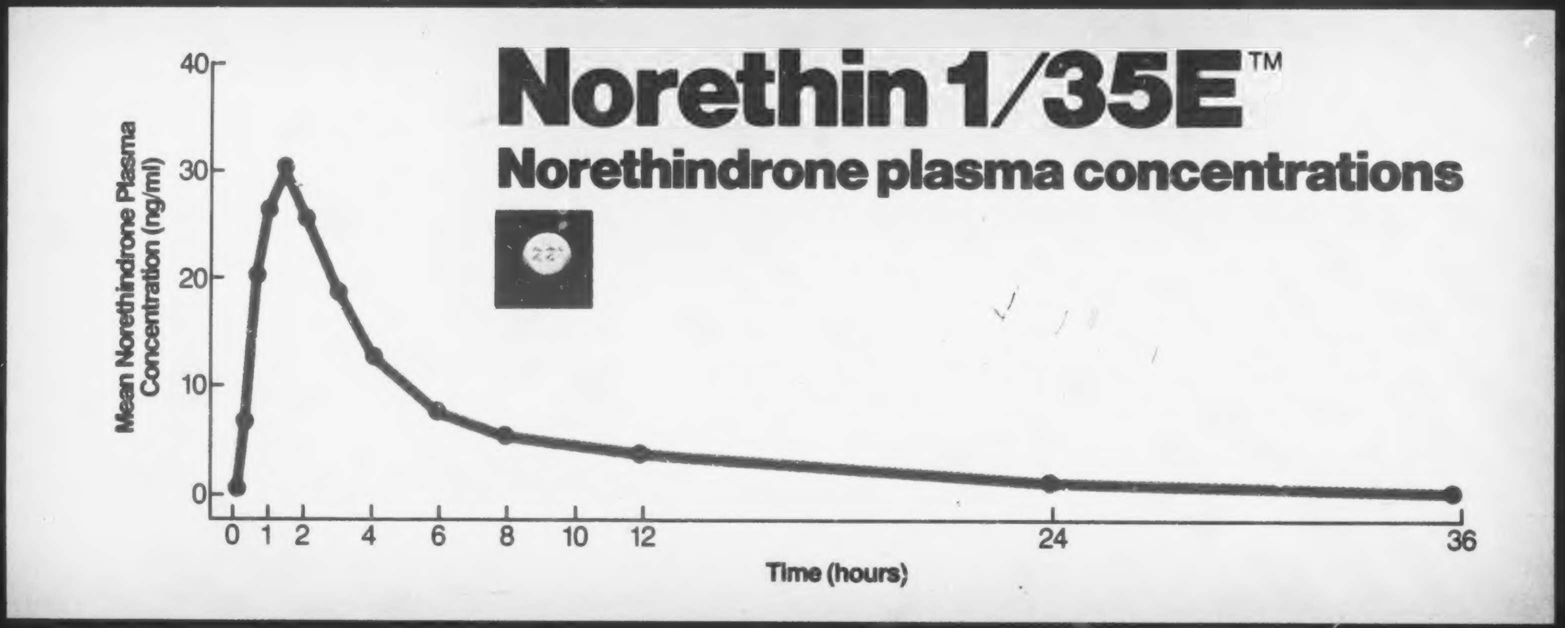
Drug wholesalers: expense and profit trends

	1984	1985	1986	1987	1988
Gross profit*	9.74%	8.86%	8.19%	7.60%	7.34%
Operating expenses	6.84	6.17	5.98	5.28	4.99
Net operating income*	2.90	2.68	2.21	2.31	2.34

*FIFO results

Source: NWDA 1988 Operating Survey





Adapted from Kunka RL[1]

Bioequivalent ...but not equal[†]

One of these oral contraceptives costs 50% more than the other.

*Ortho-Novum 1/35 (norethindrone 1 mg/ethinyl estradiol 35 mcg) is a registered trademark of Ortho Pharmaceutical Corporation.

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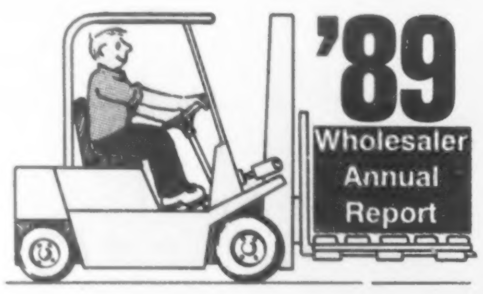
Drug wholesaler industry profitability trends

Indicators	1984	1985	1986	1987	1988
Return on net worth	16.4%	13.1%	9.7%	12.8%	11.3%
Return on total assets	7.3	6.1	4.6	5.6	4.7
Net profit margin	1.8	1.5	1.1	1.3	1.1
Total asset turnover	4.1	3.9	3.9	4.1	4.2
Gross profit margins	9.7	8.9	8.2	7.6	7.3

Source: NWDA 1988 Operating Survey

Profile: Slimmer Alco improves service



VALLEY FORGE, Pa. — For the past nine months, Alco has been on a consolidation program that resulted in the closing of five distribution centers.

When Alco consolidates, it prefers to leave sales and customer service divisions in place so the only change the customer sees is orders arriving from a different place.

John McNamara, president, said the consolidation benefits the customer as well as Alco. "They actually get a higher level of service because we have a bigger DC and stock more variety, up to 35,000 items."

Alco now has what McNamara calls a "transparent ordering system," meaning that all orders now go into one computer system.

If a retailer in Louisville, for example, orders something that his local warehouse doesn't have, the computer determines from where that product can be shipped, and it is automatically sent to Louisville. The retailer, however, doesn't have to bother about paying a second bill or getting two deliveries. As far as he's concerned, that product came from Louisville. He gets one shipment and one invoice.

Alco may be the only large wholesaler stocking a full line of cosmetics: they own a specialty company called Rita Ann cosmetics which services a 30-state area. Rita Ann has its own sales force to solicit orders, and the product is delivered direct to the store.

Alco offers its customers a full catalog of value-added services including a radio, TV and circular advertising program geared to local markets, in-store planograming assistance, their own private label line and a broad prescription generic program that includes a "prime source" that allows retailers to buy directly from the manufacturer.

Realizing that there are still many independents whose stores aren't big enough to be full-line drug stores or to stock a large assortment of front-end products, Alco created a new marketing program for the small independent who does most of his sales in pharmacy and over-the-counter products. It's a voluntary program similar to its Family Independent Pharmacist, called the Family Independent Pharmacy Prescription Center.

It includes a private label and generic prescription program, a senior citizen marketing program, and ad support that's geared more to the pharmacy and OTC departments.

At press time, Alco was rolling the program out into most of its markets, and McNamara said he thought it will increase the number of Family Independent Pharmacist customers by some 25 percent to 30 percent.

Alco is also installing a new common or centralized computer system that should be on line by 1991.

Over the years, Alco has been consolidating its smaller DCs into large, more centrally located, facilities with sophisticated automated equipment. It is trying a carousel picking machine in one facility, which works by bringing the product to the picker on a programmed basis.

rom the plasma concentrations[1] of ethinyl stradiol and norethindrone produced by rtho-Novum 1/35 (norethindrone 1 mg, thinyl estradiol 35 mcg) and Norethin 1/35E norethindrone 1 mg, ethinyl estradiol 5 mcg), there doesn't seem to be any ifference between them. Or does there?

They *are* bioequivalent.[1] Norethin 1/35E s AB-rated[2] as a therapeutic equivalent or both Ortho-Novum 1/35 and orinyl® 1+35.‡ But the substantial difference in cost means that when you sell orethin you can pass along significant avings to your customers.

Vell below the Federal MAC[3]

With an AWP of only $8.15,[4] Norethin /35E costs less than ⅔ as much as rtho-Novum 1/35 ($13.75[4]) and ½ as much as Norinyl 1+35 ($16.30[4]), putting it vell within the $10.42/cycle Federal MAC uideline for reimbursement.

earle—a name you AND your customer can trust

Something besides price sets Norethin apart: Searle, its developer and manufacurer, has been making oral contraceptives or nearly 30 years—longer than anyone lse. So when you substitute the fully AB-rated Norethin, you're giving your ustomer everything she ever got from rtho-Novum or Norinyl. And more.

For less.

orethin 1/35E™
norethindrone 1 mg, ethinyl estradiol 35 mcg)

orethin 1/50M™
norethindrone 1 mg, mestranol 50 mcg)

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References: 1. Kunka RL: Results of bioequivalence studies of Norethin 1/35E™ (norethindrone 1 mg, ethinyl estradiol 35 mcg) and Norethin 1/50M™ (norethindrone 1 mg, mestranol 50 mcg). *US Medical and Scientific Affairs*, G.D. Searle & Co., 1987. Available from Department of Medical Relations, G.D. Searle & Co., Skokie, IL 60077. 2. Approved Drug Products with Therapeutic Bioequivalence Evaluations (ed 8). US Dept of Health and Human Services, 1-4, 1988. An AB rating designates a product as therapeutically equivalent to another pharmaceutical. 3. *State Medicaid Manual*, pt 6: Payment for Services. HCFA Publication 45-6, Addendum A, pp A-10, A-16. Dept of Health and Human Services, April 1989. 4. Drug Topics *Red Book Update*, April 1989, pp 22-24.

‡Norinyl 1+35 (norethindrone 1 mg, ethinyl estradiol 35 mcg) is a registered trademark of Syntex Laboratories.

The physician should become familiar with the prescribing information (labeling) for this product, which discusses reported risks, such as thromboembolic disorders (including strokes and heart attacks) and hepatic lesions, as well as the need to monitor patients for early symptoms of any diseases or medical conditions, so use can be discontinued where appropriate. A *brief summary* of prescribing information is presented on the following page.

NDC 0014-0441
Norethin 1/50M™-28
(norethindrone and mestranol tablets USP)
Each white tablet contains norethindrone 1 mg and mestranol 50 mcg.
Each blue tablet contains inert ingredients.
NDC 0014-0231
Norethin 1/35E™-28
(norethindrone and ethinyl estradiol tablets USP)

Equivalent to Ortho-Novum,

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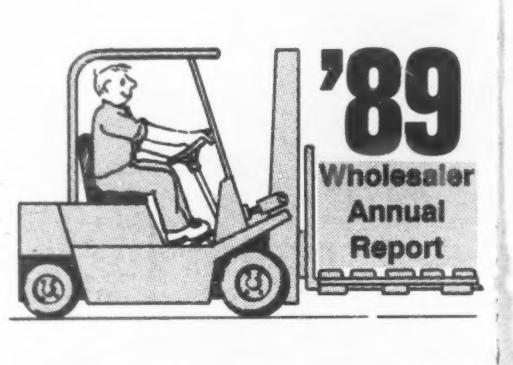
Profile: Bindley seeks to increase presence



INDIANAPOLIS — Chairman and ceo Bill Bindley says the main focus at Bindley Western this past year has been to "increase our presence in our traditional drug store markets."

Bindley has always specialized in servicing chain drug warehouses, but to handle this particular customer base efficiently, Bindley has had to operate with extremely low margins, low even for this industry.

To compensate for this, Bindley began expanding into other business areas back in the early '80s.

In 1980, for example, about 4 percent of Bindley's sales were direct to stores, hospitals or other clients. That percentage has since grown to nearly 18 percent of Bindley's annual sales.

Like many wholesalers, Bindley is also upgrading its warehouses. New facilities are larger and utilize fully mechanized conveyor systems.

In the past year and a half, Bindley expanded its product mix, tripling the number of SKUs in the warehouse. Today Bindley Western considers itself a "full line wholesaler", as far as front-end merchandise is concerned. In its largest warehouse, it stocks over 18,000 SKUs. That facility acts as a supplier to the smaller warehouses in the Bindley system.

Bindley has also upgraded four of its warehouses with a computerized conveyor pick. The plan is to expand the system, which can handle single pick orders, to two more facilities within the coming year.

To help strengthen promotional support to retailers, Bindley acquired Northeast Food Distribution, a small distributor of non-perishable food headquartered in Boston, and can now provide non-perishable, traffic-building grocery items (such as coffee, tuna, and pet foods) for *all* its retail customers, chains as well as independents.

"It could turn out to be a growth area for us. I don't know for sure," Bindley said of promotional groceries, but he sees the category as a way to service his customers better as well as a way to take advantage of the distribution system now in place.

Although Bindley is not interested in the home health care market, he is selectively pursuing the hospital market. "If the margins are too low, we pass on a lot of bids," he said.

Bindley changed its data processing program and is now using a PC-based system for communicating with retailers and hospitals. Retailers and hospitals who use the system, which is tailored to the needs of individual customers, can access the Bindley data bank at any time for items like price updates, placing orders, or securing any information needed to operate their businesses more effeciently.

Bindley also has its own generic prescription program which the company constantly evaluates. Bindley is taking a wait-and-see attitude toward the current furor over generics, saying he plans no changes in his own program, but may make some down the line.

BRIEF SUMMARY

Norethin 1/35E™ Each white tablet contains norethindrone 1 mg and ethinyl estradiol 35 mcg. Each blue tablet in Norethin 1/35E-28 is a placebo containing inert ingredients.

Norethin 1/50M™ Each white tablet contains norethindrone 1 mg and mestranol 50 mcg. Each blue tablet in Norethin 1/50M-28 is a placebo containing inert ingredients. **Indication and usage:** For prevention of pregnancy. Pregnancy rate for products with ≥35 mcg ethinyl estradiol or ≥ 50 mcg mestranol is ≤1/100 woman-years. With ≤35 mcg ethinyl estradiol, rate is slightly higher; with progestogen-only oral contraceptives (OCs), rate is about 3. Precise comparisons cannot be made. Rates for other methods have been published. *Dose-related Thromboembolic Risk.* Studies showed positive association between OC estrogen dose and thromboembolic risk. It is in keeping with good therapeutics to minimize estrogen exposure. Prescribe product containing least amount of estrogen compatible with acceptable pregnancy rate and patient acceptance. Start new users on ≤50 mcg estrogen. **Contraindications:** Thrombophlebitis, thromboembolic disorders, past history of deep vein thrombophlebitis or thromboembolic disorders; cerebrovascular disease, myocardial infarction or coronary artery disease, or past history of these; known or suspected breast carcinoma, estrogen-dependent neoplasia, or pregnancy; undiagnosed abnormal genital bleeding; past or present, benign or malignant liver tumors developing during use of estrogenic products. **Warnings:**

Cigarette-smoking increases risk of serious cardiovascular side effects from OC use. Risk increases with age and heavy smoking (15 or more cigarettes/day) and is quite marked in women over 35. OC users should be strongly advised not to smoke. OCs are associated with increased risk of several serious conditions including venous and arterial thromboembolism, thrombotic and hemorrhagic stroke, myocardial infarction, visual disorders, hepatic tumors, gallbladder disease, hypertension, fetal abnormalities. Practitioners should be familiar with the available information relating to these and other risks.

1. *Thromboembolic disorders and other vascular problems:* Increased risk of thromboembolic and thrombotic disease associated with OCs is well established. A British study showed increased risk for fatal venous thromboembolism (TE). British and U.S. studies showed increased risk for nonfatal disease. U.S. studies showed increased risk for stroke. OC users were 2-11 times more likely to manifest these diseases without evident cause. In a study of idiopathic deep vein thrombosis and pulmonary embolism (PE), projected hospitalization rates for ages 16-40 were 47/year/100,000 users and 5 for nonusers. Overall excess mortality from PE or stroke was 1.3-3.4 deaths/year/100,000 users and increased with age. *Cerebrovascular Disorders:* In a study of stroke with and without predispositions, risk of hemorrhagic stroke was 2 times greater and thrombotic stroke 4.0-9.5 times greater in users. Mortality trends in 21 countries indicate that changes in cardiovascular mortality were associated with changes in OC prevalence. The Royal College of GPs (RCGP) reported on its prospective study: "A statistically significant higher rate of reporting of cerebrovascular accidents in Takers is evident, but the numbers are too small to justify an estimation of the degree of risk." A 1981 analysis showed a 4-fold increased mortality in users from circulatory diseases, mainly myocardial infarction (MI) and hemorrhagic stroke. Excess mortality was associated with age and smoking. A 1983 analysis showed elevated cerebrovascular disease, increasing with use to 8 yrs, including cerebral thrombosis or embolism and TIA. Peripheral arterial disease and MI were increased. Women over 30 had more arterial disease, being greatest in smokers. Arterial case-fatality was 2-3 times greater for users who smoked. Family Planning Assoc. (FPA) found significant association between OC use and stroke; increased risk for venous thrombosis and PE was 4-fold and statistically significant. Mortality from nonrheumatic heart disease was greater in ever-users. In the Walnut Creek Study, subarachnoid hemorrhage risk was associated with smoking, age, and OC use. *Myocardial Infarction:* Increased risk of MI associated with OCs was reported in Britain, as previously suspected. The morbidity study found the greater the number of risk factors for coronary artery disease (smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) the higher the risk, regardless of OC use. OCs were an additional risk factor. Excess rate of fatal MI was 3.5/year/100,000 users aged 30-39 and 20 for ages 40-44. (These are based on British statistics with acute MI death rates 2-3 times less than the U.S. Similar estimates for the U.S. are 25.7 for users aged 30-39 with predispositions vs 1.5 without; for ages 40-44, 86.2 vs 5.1.) Excess hospitalization rate for nonfatal MI in Britain was 3.5/year/100,000 users aged 30-39 and 47 for ages 40-44. Smoking major predisposing condition to MI. In terms of relative risk, nonsmoking OC users are twice as likely to have fatal MI as nonsmoking nonusers. Smoking users have a 5-fold greater risk than nonsmoking users, but a 10-12-fold greater risk than nonsmoking nonusers. Amount of smoking is an important factor. In determining importance of these risks, give serious consideration to rates in table below. Importance of other predispositions cited above in determining relative and absolute risks has not been quantified; it is likely the same synergism exists, but perhaps to a lesser extent. U.S. studies similarly relate MI, OCs, smoking, and age.

Estimated Mortality Rate from Myocardial Infarction per 100,000 Women/Year

	Aged 30-39:	*Users*	*Nonusers*	*Aged 40-44:*	*Users*	*Nonusers*
All smokers		10.2	2.6		62.0	15.9
≥15 cigarettes daily		13.0	5.1		78.7	31.3
<15 cigarettes daily		4.7	0.9		28.6	5.7
Nonsmokers		1.8	1.2		10.7	7.4
Smokers and nonsmokers		5.4	1.9		32.8	11.7

Risk of Dose: Reports of TE after use of OCs with ≥50 mcg estrogen received by drug safety committees in Britain, Sweden, and Denmark were compared with distribution expected from market research sales estimates. A positive correlation was found between estrogen dose and reporting of TE, including coronary thrombosis, in excess of that predicted by sales. OCs with ≥100 mcg estrogen were associated with higher TE risk than those with 50-80 mcg. Estrogen quantity may not be the sole factor; influence of progestogens was not considered, which may be responsible for certain discrepancies in the data. No significant differences were noted between OCs containing same estrogen dose nor between ethinyl estradiol and mestranol. In Britain certain TE conditions were associated with progestogen or estrogen dose. In Sweden reports of TE decreased when higher estrogen doses were no longer prescribed. Studies on TE risk with progestogen-only OCs have not been done. Cases have been reported for these; they are not presumed free of risk. In a U.S. case-controlled study, relative risk of OC use 1 month before hospitalization for various types of TE was calculated. If relative estrogenic potency and possible influence of different progestogens are ignored, OCs may be divided into those with <100 mcg and those with ≥100 mcg estrogen. For all cases combined, larger doses were associated with only slightly higher risk; for idiopathic cases risk was doubled with larger doses, but confidence limits overlapped and differences were not significant. Apparently there was less increased risk for cases with predispositions. In FPA study no nonhemorrhagic strokes occurred with <50 mcg estrogen, vs 13 with higher doses. TE risk in users and nonusers increases with age. OCs have been considered an independent risk factor. *Persistence of Risk* after OC discontinuation was reported for circulatory disease, nonrheumatic heart disease, and cerebrovascular disease, including subarachnoid hemorrhage, cerebral thrombosis, and TIA. *Excess Mortality from Circulatory Diseases:* A U.K. prospective study estimated annual mortality from circulatory diseases for OC users and nonusers by age, smoking, and duration of use. Excess mortality was 23/100,000 users (2 and 10 for ages 25-34, 15 and 48 for ages 35-44, 41 and 179 for ages >44, for nonsmokers and smokers, respectively). Risk was significant only for smokers over 34. Most deaths were due to subarachnoid hemorrhage or ischemic heart disease. Risk for ever-users rose with parity. One study estimated risk of death with various contraceptive methods, each estimate including risk of method (eg, TE for OCs) plus risk due to pregnancy or abortion in cases of method failure. This latter risk varies with effectiveness. It concluded mortality with all methods is low and below that of childbirth, except for OC users over 40 who smoke. Heavy smokers have double the risk of smokers, light smokers about half. Mortality with OC use in nonsmokers over 40 is higher than with any other method in that age group. Lowest mortality is with condom or diaphragm backed up by early abortion. Risk of TE and thrombotic disease with OCs increases with age after 30 and, for MI, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia, and especially cigarette smoking. Based on current data, the chart gives gross estimates of risk of death from circulatory disorders associated with OCs:

Risk is: A—very high; B—high; C—moderate; D—low.	Age:	<30	30-39	≥40
Heavy smokers (≥15/day)		C	B	A
Light smokers (<15/day)		D	C	B
Nonsmokers, no predispositions		D	C,D	C
Nonsmokers, with predispositions		C	C,B	B,A

Be alert to earliest manifestations of TE and thrombotic disorders (eg, thrombophlebitis, PE, cerebrovascular insufficiency, coronary artery disease, MI, retinal thrombosis, mesenteric thrombosis). Should any be suspected, discontinue OCs immediately. A 4-7-fold increased risk of postsurgery TE was reported in users; if feasible discontinue OCs at least 4 weeks before surgery or in prolonged immobilization. Before resuming OCs, weigh risks of postsurgery TE complications against contraceptive needs. The RCGP prospective study reported higher incidence of superficial and deep vein thrombosis in users, the former correlated with progestogen dose. The data suggest varicose veins have little effect on development of deep vein thrombosis but substantially increase risk of superficial vein thrombosis, risk depending on severity of varicosities. **2.** *Ocular lesions:* Neuro-ocular lesions such as optic neuritis or retinal thrombosis have been associated with OCs. Discontinue if there is unexplained, gradual or sudden, partial or complete loss of vision; proptosis or diplopia; papilledema; or evidence of retinal vascular lesions. Institute diagnostic and therapeutic measures. **3.** *Carcinoma:* Long-term estrogen in certain animals increases carcinomas and/or nonmalignant neoplasms, such as those of breast, uterus, cervix, vagina, ovary, liver, pituitary. Some synthetic progestogens, none currently in OCs, increase incidence of benign and malignant mammary nodules in dogs. There is evidence that estrogens increase risk of human endometrial carcinoma. In case-controlled studies, increased risk (2.2-13.9 times) associated endometrial carcinoma with prolonged estrogen for menopausal symptoms. Risk was independent of other known risk factors and depended on duration of use and dose. This is supported by increased endometrial cancer incidence since 1969 in areas with cancer-reporting systems, which may be related to rapidly expanding estrogen use. There is no evidence that natural estrogens are more or less hazardous than synthetics at equi-estrogenic doses. Of the first 30 cases of endometrial carcinoma in OC users under 40, those without predispositions (eg, irregular bleeding before OCs, polycystic ovaries) occurred nearly always with no-longer-marketed sequential OCs. No statistical association is reported suggesting increased endometrial cancer with combination or progestogen-only OCs, though individual cases were reported. Studies show no increased breast cancer with OCs or estrogens. However, greater risk was noted in OC users with benign breast disease or long-term (2-4 years) use. One study found greater risk of breast cancer with >4 years OC use prior to first full-term pregnancy. Risk of breast cancer with menopausal estrogens rose and further increased with duration of follow-up. OCs or estrogen were related to breast cancer in connection with other risk factors. Decrease in benign breast tumors in OC users is well known. Some studies suggested increased risk of cervical dysplasia, erosion, and carcinoma in long-term users. Cervical microglandular hyperplasia has been reported. In summary, there is no consistent evidence from human studies of increased cancer risk with OCs. Close surveillance is, however, essential. In undiagnosed persistent or recurrent abnormal vaginal bleeding, consider nonfunctional causes and take diagnostic measures to rule out malignancy. Carefully monitor users with strong family history of breast cancer or with breast nodules, fibrocystic disease, recurrent cystic mastitis, abnormal mammograms, or cervical dysplasia. **4.** *Hepatic adenomas, etc,* have been associated with OCs. In 1 study OC formulations with high "hormonal potency" were associated with higher risk, as was age over 30. Though benign, these lesions may rupture and cause fatal hemoperitoneum in short- or long-term users. Two studies related risk to duration of use, being much greater after ≥4 years. Long-term OC users have an estimated adenoma incidence of 3-4/year/100,000. Consider such lesions in users with abdominal pain, tenderness, mass, or shock. About 25% present with abdominal masses, up to half with acute hemoperitoneum. Radiologic and lab studies may not be helpful; liver scans may show local defect. Hepatic arteriography or CAT may be useful. Hepatocellular carcinoma risk is increased 7-20 times in users for 8 or more years. Bile duct cancer may occur with OC use. OCs are contraindicated in case of past or present, benign or malignant liver tumors developing during use of estrogenic products. **5.** *Use in or immediately preceding pregnancy, birth defects, malignancy in offspring:* Estrogens or progestogens during early pregnancy may seriously damage offspring. Females exposed in utero to DES and other nonsteroidal estrogens may have increased risk of vaginal or cervical cancer. Though OCs may not enhance this risk, monitor such patients carefully. From 30-90% of DES-exposed women develop benign vaginal or cervical adenosis, which could be premalignant. DES-exposed daughters have more unfavorable pregnancy outcomes. Males so exposed may develop urogenital and sperm defects. Other estrogens may mimic DES. Reports relate fetal exposure to female sex hormones and congenital anomalies, eg, VACTERL for vertebral, anal, cardiac, tracheoesophageal, renal, and limb defects. There appears preferential expression by males. There was a 4.7-fold increased risk of limb-reduction defects in infants exposed in utero to sex hormones (OCs, hormonal withdrawal pregnancy tests, or treatment for threatened abortion). Some exposures were very short, being only a few days. Cardiovascular defects in children exposed to female hormones, including OCs, during early pregnancy occurred in 18.2/1,000 births, compared to 7.8 for those unexposed (P<.05). More twinning was reported in conceptions shortly after OC discontinuance. Female sex hormones were used for threatened or habitual abortion, but there is considerable evidence estrogens are ineffective and no evidence progestogens are effective. Triploidy and possibly other polyploidy may be increased in abortuses from women becoming pregnant soon post-OC. These almost always abort spontaneously. It is unknown if spontaneous abortion is increased soon after stopping OCs. Increased chromosome aberrations have been reported. Safety of OCs in pregnancy has not been demonstrated. Rule out pregnancy in using OCs and always consider it if withdrawal bleeding does not occur. If 2 consecutive periods are missed rule out pregnancy before continuing. If user deviates from regimen, consider pregnancy at first missed period and withhold OCs. If pregnancy is confirmed, apprise patient of potential fetal risks and discuss continuation of pregnancy. Users discontinuing for pregnancy should use alternative contraception for 3 months before attempting to conceive, though this is not based on precise information. Do not use progestogen-only or progestogen-estrogen drugs as pregnancy tests. **6.** *Gallbladder disease* risk, surgically confirmed, appeared after 2 years' use and doubled after 4-5 years in 1 study; it appeared in 6-12 months' use in another. **7.** *Carbohydrate and lipid metabolism:* Decreased glucose tolerance occurs in a significant number of users; carefully observe diabetic and prediabetic patients. Triglycerides, total phospholipids, and lipoproteins may increase. **8.** *Elevated blood pressure* (BP) occurs in some users in a few months, and degree may relate to progestogen dose. Hypertension prevalence in users is not higher in the first year, but increases with longer exposure; in the 5th year it is 2½—3 times the first year. Age is strongly correlated with hypertension in users. Those with history of elevated BP (hypertension), preexisting renal disease, history of toxemia or elevated BP in pregnancy, familial tendency to hypertension or its consequences, or history of excessive weight gain or fluid retention during menstrual cycles may be more likely to develop elevated BP on OCs and should be monitored closely. Even though elevated BP may be in "normal" range, do not ignore implications. Follow closely, particularly those with other risk factors for cardiovascular disease or stroke. High BP may or may not persist after stopping OCs. **9.** *Headache:* Onset or exacerbation of migraine or development of headache of a new pattern that is recurrent, persistent, or severe requires stopping OCs and evaluating cause. **10.** *Bleeding irregularities:* Breakthrough bleeding (BTB), spotting, and amenorrhea are frequent reasons for discontinuing. In BTB, as in all cases of irregular bleeding, consider nonfunctional causes. In undiagnosed persistent or recurrent bleeding, rule out pregnancy or malignancy. If pathology is excluded, time or change to another product may suffice. Change to a higher-estrogen OC only when necessary as this may increase thromboembolic risk. Those with history of oligomenorrhea or secondary amenorrhea or without established regular cycles may be anovulatory or amenorrheic after discontinuing. Those with such problems should be so informed and other methods encouraged. Post-use anovulation, possibly prolonged, may occur in women without previous irregularities. Higher incidence of galactorrhea and of pituitary tumors has been associated with postpill amenorrhea. One study reported 16-fold increased prevalence of pituitary prolactin-secreting tumors in patients with postpill amenorrhea when galactorrhea was present. **11.** *Ectopics:* In failures with combination OCs, the ratio of ectopic to intrauterine pregnancies is no higher than in nonusers. There may be increased risk of ectopics after discontinuing. **12.** *Breast feeding:* OCs may decrease quantity and quality of milk. A small fraction of OC steroids appears in milk. Effects if any on child are unknown. If feasible defer OCs until after weaning. **13.** *Infertility* may occur after discontinuing OCs. While impairment diminishes with time, there is still an appreciable difference in nulliparas aged 25-29 after 30 months; difference is negligible after 48 months. In nullips aged 30-34 impairment persists to 72 months and is more severe for 2-year users. In paras aged 25-34, difference is negligible after 30 months. **Precautions:** Conduct complete history and physical prior to OC use and annually thereafter. Include breasts, abdomen, and pelvis, with BP, Pap, and lab tests. Preexisting uterine leiomyomata may enlarge. Mental depression may occur; with positive history, observe carefully and discontinue if serious recurrence. Fluid retention may occur; prescribe cautiously and monitor carefully in convulsive disorders, migraine, asthma, or cardiac, hepatic, or renal dysfunction. History of jaundice in pregnancy increases risk of recurrence on OCs; observe carefully and discontinue if it occurs. Cholestatic jaundice occurred after OC and troleandomycin use. OC/cyclosporine combination may be hepatotoxic. Steroids may be poorly metabolized in liver dysfunction and should be given cautiously. Tryptophan metabolism may be disturbed and result in pyridoxine deficiency; megaloblastic anemia has been reported. Serum folate may be depressed and may be exacerbated in post-OC pregnancy. Advise pathologist of OC use when submitting specimens. Endocrine and liver function tests may be altered; repeat abnormal tests after stopping for 2 months. These have been observed: increased BSP retention and other abnormalities in liver function tests; increased prothrombin and coagulation factors VII, VIII, IX, X; decreased antithrombin III, increased platelet aggregability; increased thyroid-binding globulin leading to increased circulating total thyroid hormone (PBI, T^4); decreased T^3 uptake, unaltered free T^4, decreased pregnanediol excretion; reduced metyrapone response; increased blood transcortin, corticosteroid, triglyceride, phospholipid, reduced serum folate; impaired glucose tolerance; altered plasma trace minerals. Influence of prolonged OC use on pituitary, ovarian, adrenal, hepatic, or uterine function, or on immune response not established. OCs may mask onset of climacteric. Cervical chlamydial prevalence is increased; do not assume OC protects against chlamydial PID. *Information for patients:* See patient labeling. *Drug interactions:* OC effectiveness may be decreased and more BTB occur with rifampin, isoniazid, ampicillin, neomycin, penicillin V, tetracycline, chloramphenicol, sulfonamides, nitrofurantoin, griseofulvin, barbiturates, phenytoin, carbamazepine, primidone, phenylbutazone, analgesics, tranquilizers, antimigraines. OCs may alter effectiveness of oral anticoagulants, anticonvulsants, tranquilizers, tricyclic antidepressants, antihypertensives, theophylline, caffeine, vitamins, hypoglycemics, clofibrate, glucocorticoids, acetaminophen. **Adverse reactions:** Increased risk of the following serious adverse reactions has been associated with OCs: thrombophlebitis and thrombosis; pulmonary embolism; arterial thromboembolism; Raynaud's disease, myocardial infarction; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; Budd-Chiari syndrome; benign adenomas and other hepatic lesions, with or without intra-abdominal bleeding, liver cancer, congenital abnormalities. There is evidence of association between the following and OCs, though confirmatory studies have not been done: mesenteric thrombosis; neuro-ocular lesions, eg, retinal thrombosis and optic neuritis. The following are believed drug related: nausea, vomiting, gastrointestinal symptoms, BTB, spotting, change in menstrual flow, dysmenorrhea, amenorrhea during and after use, infertility post-OC, edema, chloasma or melasma which may persist post-OC, breast changes (tenderness, enlargement, secretion), weight changes, change in cervical erosion and secretion, endocervical hyperplasia, lactation decrease, cholestatic jaundice, migraine, enlarged uterine leiomyomata, allergic rash, mental depression, reduced carbohydrate tolerance, vaginal candidiasis, change in corneal curvature (steepening), intolerance to contact lenses. Association not confirmed or refuted for: premenstrual-like syndrome, cataracts, libido changes, chorea, appetite changes, cystitis-like syndrome, headache, paresthesia, nervousness, dizziness, auditory disturbances, rhinitis, fatigue, backache, hirsutism, scalp hair loss, erythema multiforme or nodosum, hemorrhagic eruption, herpes gestationis, hemolytic uremia, malignant hypertension, itching, vaginitis, porphyria, impaired renal function, acute renal failure, sometimes irreversible, PVCs, abnormal EKG, pulmonary hypertension, TTP, anemia, pancreatitis, hepatitis, colitis, Crohn's disease, gingivitis, dry socket, lupus erythematosus, rheumatoid arthritis, pituitary tumors (eg, adenoma) with amenorrhea and/or galactorrhea after use, malignant melanoma, endometrial, cervical, breast, and bile duct carcinoma. **Acute overdosage:** Serious ill effects have not been reported after large acute doses of OCs in young children. Nausea and withdrawal bleeding might occur. **Important note: Complete prescribing information should be consulted prior to use and is available on request.**

11/16/87 • P87-S4730V

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INSIDE
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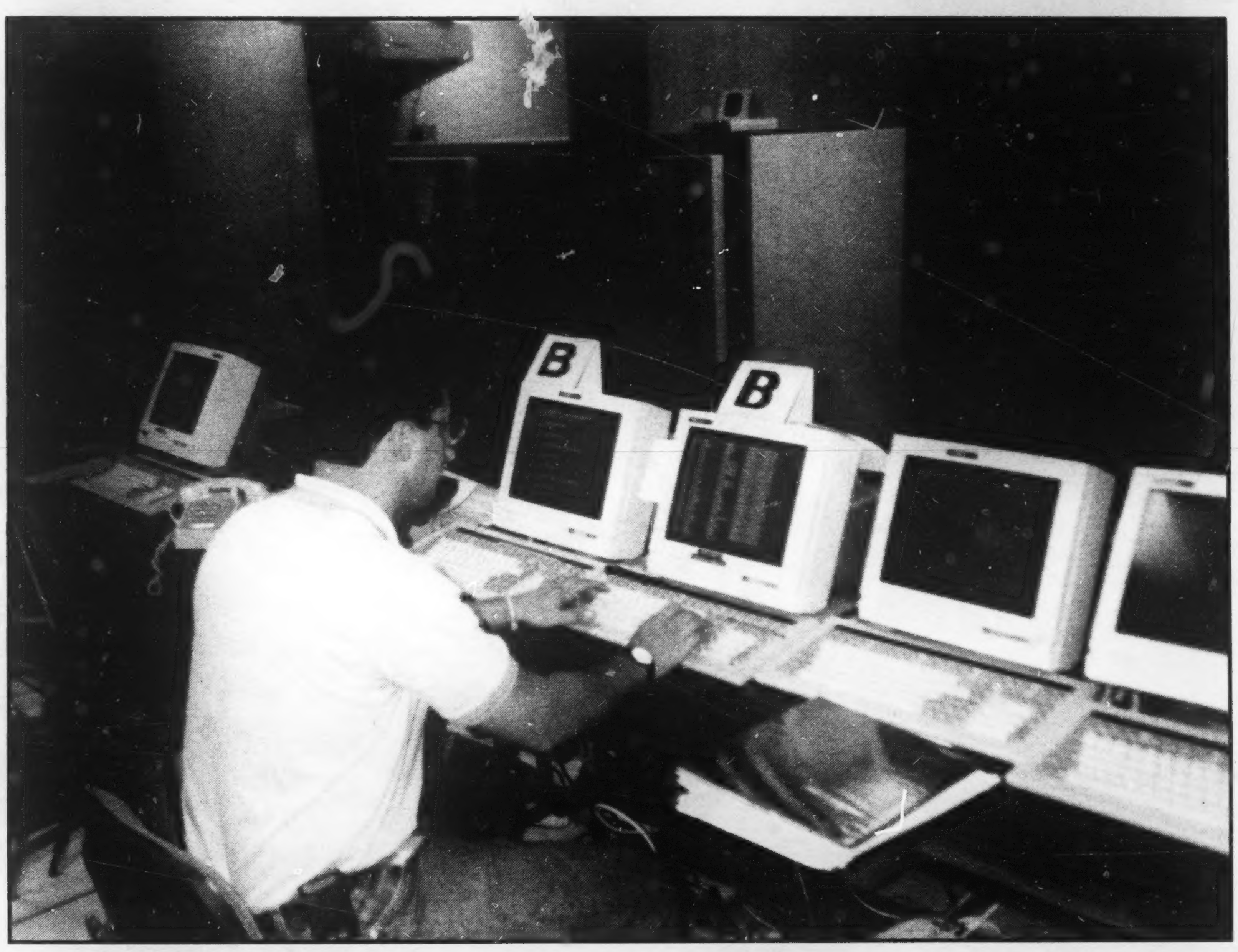
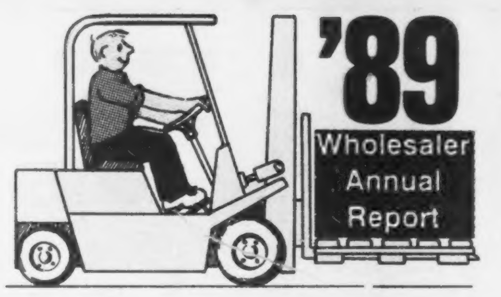


Computers have made it possible for wholesalers to drop operating expenses to lowest point ever: 4.99 percent of sales in 1988, according to NWDA.

Profile: New era at Harris starts with Meyers at helm



SOLON, Ohio — This year Harris Wholesale Co. has a new president, Don Meyers, who has spent 12 years with Harris, most recently as executive vp and chief operations officer.

Seth Harris will still continue as a force at Harris, serving as ceo and vice chairman, but has the additional responsibility of trying to build a synergistic program for Harris and its sister divisions, especially General Medical Corp., the second largest distributor of medical-/surgical supplies in the nation.

Both companies, as well as a financing company and a private label manufacturer, are owned by New York-based RAB Holdings. Harris was acquired by RAB a little more than a year ago.

Meyers says Seth will be "getting out of the day-to-day operations at Harris to do more with RAB's other holdings. We want to be the premiere health organization in the country," he said, referring to RAB's opportunity to link together the health care companies it owns.

In the past year, Harris aggressively began laying the groundwork for future growth. It expanded its presence in Florida by opening a large, modern facility in Lakeland and closing a much smaller center in Miami.

Meyers said Florida is a "dynamic market" and that Harris has "big plans for expanding there."

Harris has a new facility for Cleveland on the drawing board. Referring to it as a "state of the art" facility, Meyers said the company hopes to occupy it in 1991.

In terms of technology, Harris is not experimenting with some of the costlier systems being used by bigger companies like Bergen and McKesson, but is adding stand-alone computers to all facilities, a program that should be completed by March. Once on line, all divisions will be able to talk to the mainframe in Cleveland as well as to all customers and suppliers electronically.

Harris is also beefing up value-added services for retailers and trying to grow hospital business by positioning itself as a one-source supplier. When Harris and General Medical team up, hospitals will be able to get almost all their supplies from one organization. Harris supplies the pharmaceuticals and General Medical supplies all the surgical/medical supplies.

This year, Harris started a circular advertising program for Health Plus voluntary members, and kicked off a new zone pricing program.

Average sales per wholesaler distribution center

Company	Number of main distribution centers		Dollar sales per distribution center (millions)
	1988	1989	
Humiston-Keeling	1	1	$464
Moore Medical	1	1	232
Drug Guild	1	1	220
Walker Drug	1	1	180
Newman Wholesalers	1	1	178
Twin City	1	1	165
Fox Meyer	13	12	162
North Carolina	1	1	145
Harris	7	5	143
McKesson	48	47	120
Bergen	32	31	120
F. Dohmen Co.	1	1	119
J.E. Gould	1	1	119
Cardinal	6	6	117
Solomon Drug	1	1	110
Bindley Western	11	11	100
Remo Drug	1	1	100
James Brodnick	1	1	95
Durr Fillauer	5	5	77
Northwestern (Minn.)	1	1	72
Alco	31	26	66
Value Drug	1	1	65
Dr. T.C. Smith	2	2	60
Owens & Minor	4	4	58
Ketchum	4	4	58
Walsh-Lumpkin	1	1	53
Kendall	1	1	46
Dik Drug	2	2	45
South Bend	2	2	44
Prescription Supply	1	1	3
Amfac	31	32	31
Northern Drug	1	1	30
Chapman Drug	6	6	28
Miami-Luken	3	3	22
C. D. Smith	2	2	15

Source: *Drug Store News*/NWDA 1989 Wholesaler Survey

Drug wholesalers: product sales mix

(Percentage of net drug wholesaling sales)

Product Line	1979	1985	1986	1987	1988
Pharmaceutical	63.4%	75.8%	76.4%	77.8%	77.0%
Proprietary	17.5	12.5	12.5	12.2	11.3
Toiletry/H&BA	9.7	5.9	4.5	4.0	7.0
Sundry	8.3	3.8	4.3	3.1	2.6
DME and HHC**	—	0.5	1.1	1.1	1.0
Other	1.3	1.5	1.3	0.9	1.1

**Durable Medical Equipment and Home Health Care

Source: 1988 NWDA Operating Survey

Wholesalers carry a broad assortment of front-end products today, including foods. Their goal: becom a full-line supplier for today's full-line retailers.

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PHARMACY

CE LESSON

Continued from page IP37

assessment in the selection of a given drug based on the individuals' medical condition. Ethically, a pharmacist has a duty to assist a patient in the proper use of a prescribed medication. Legal requirements for this professional activity, however, are not commonplace at this time.

Misfillings or violations in professional practice standards *do* have legal and professional implications that will certainly lead to eventual periodic or regular increases in professional liability premiums.

Pharmacy practitioners need to act quickly and responsibly on behalf of themselves, employers and patients to keep ahead of the rising tide of litigation. Simple liability exposure management steps will help to minimize future litigation exposure due to misfillings, errors in judgement or violation of professional practice standards.

Professional liability and malpractice

The term risk management is derived from the financial or insurance use meaning a way to conduct business that avoids or minimizes the chance for a loss. For pharmacy and pharmacists, that would mean addressing legal liability exposures on professional as well as business levels.

Business risk management is not the subject of this lesson, however, it involves traditional business losses such as when someone slips or falls in your place of business. Professional liability risk management, on the other hand, has it roots in medical and hospital settings. In hospitals, there are full-time staff members who monitor the care provided to patients and identify potential risks for liability as a result of that care. The focus there is on the nursing, housekeeping and medical staff. The objective is to identify risks before they actually cause harm to a patient or visitor in the hospital. It may be as simple as cleaning up a spill on the floor or as complicated as more accurately diagnosing patients prior to a surgical procedure. In all cases, the risk being managed is the professional duty of care to a patient. The malpractice insurance crisis of the late 1970s and early 1980s subsided somewhat in the late 1980s. Unfortunately, it is difficult to accurately determine the reason for that relief.

Insurance premiums have a cyclical nature to them in most lines of insurance coverage. There are a variety of factors for this including: the amount of coverage required for average losses, the amount of retained income by the insurance firm, the number and dollar amount of claims paid, and the number of covered individuals and type(s) of exposure that may need insurance.

A typical malpractice insurance claim brought against a hospital or physician does not appear in the legal system for two to five years. An insurance claim may not be paid for three to 10 years after the incident. Therefore, malpractice claims have a long history in reaching closure of the case versus other lines of insurance, such as automobile accident coverage where a claim can be made and closed within 30 days.

Lawyers have expanded their litigation targets beyond hospitals and physicians into other health professions during the past 10 years. Claims made against retail or hospital pharmacies and pharmacists were relatively uncommon in the 1970s. Today, professional malpractice exposure of the pharmacy profession is well documented in all practice settings.

As the role of pharmacists have changed and the utilization of pharmacists expertise has changed, so has the relative exposure to suit resulting from potential malpractice. What was considered an inconvenience to a customer in 1970 may now be considered grounds for a malpractice suit in the 1980s.

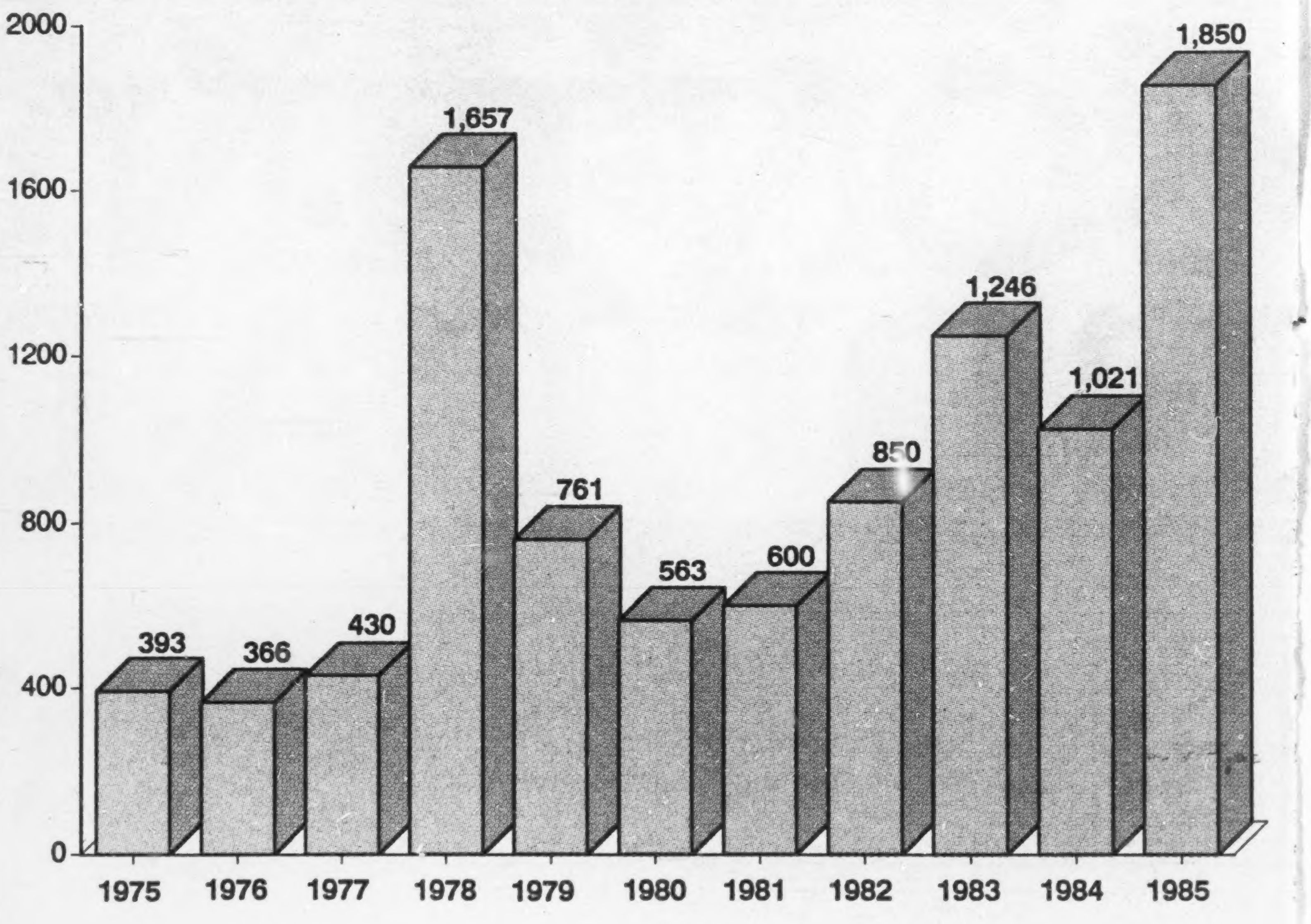
For example, a retail pharmacy dispensed the wrong drug in the right vial to a patient who subsequently discovered the error and brought suit against the pharmacist for negligence. In another case, a hospital pharmacy dispensed an incorrect intravenous order, did not properly document the order process and failed to notify the physician of the potential drug error. As a result, the hospital, hospital pharmacy, two pharmacists, a physician and two nurses were fined, and faced professional disciplinary hearings on that case in addition to the malpractice litigation. Pharmacist attorneys have published numerous other examples of cases where pharmacy has been exposed to more litigation due to increased consumer awareness of the pharmacy profession and greater expectations from the pharmacist in the delivery of health care services.

Malpractice coverage

By now you may or may not be convinced of a need for some malpractice insurance coverage as a pharmacist practitioner. Even though you may be employed and covered under your employers umbrella liability policy, as a professional there may be personal liability exposures that will not be covered under that umbrella. For example, such coverage may be limited to actions "within the scope" of your employment. That may mean you are not covered for any activity outside your job description or not performed according to your employer's policies.

AVERAGE PRODUCT LIABILITY JURY VERDICT

(In Thousands of Dollars)



SOURCE: PMA Report, 1988

Another pitfall of relying on your employer's coverage is that conflicts of interest may surface during litigation between you and your employer. Although rarely done, your employer's insurance company has reserved its rights which allow the company to recover from you what it spends on your behalf. This is called *subrogation rights*.

The mainstay against purchasing personal malpractice liability insurance has been the deep pockets theory. Pharmacists feel that no one would sue them because they have few assets when compared to their employer. What you should know, however, is that a judgement can be refiled until the pharmacist owns something of enough value to satisfy the judgement and/or garner wages. In the case of a damage award, a pharmacist may have personal belongings attached as well as have a percent of wages garnered. Carrying your own professional liability insurance is as essential as carrying automobile insurance today.

What should you look for when selecting a policy? Here are some of the items to consider:

- *How is the cost of my premium determined?* Typically, pharmacy insurance policies are dictated by your practice location, number of hours worked and type of practice.
- *What is the amount of coverage/ limit of liability?* Coverage of $1 million to $3 million annually is a common coverage selection offered to pharmacists. This means that you are covered for up to $1 million per claim up to a total of $3 million per year.
- *Is the policy claims-made or an occurence policy?* Claims-made covers the pharmacist for any claims made while they are still insured by the same policy when the claim is made against him/her. Occurrence policy will cover the pharmacist for any incident that occurred while the pharmacist was insured by that policy.
- *How does the insurance company define its terms and what protection does the policy offer the pharmacist?* Terms and coverages can vary from company to company so it is best to obtain and read the policy in advance of signing the contract.
- *How can I know exactly which of my actions are covered and which are not?* The exclusion section will tell you which actions are not covered. It may be more difficult to determine all the actions which may be covered, particularly since the practice of pharmacy has changed tremendously over the past 10 years while insurance policy language has not kept pace.
- *Who pays attorney or court fees and how do I notify the company when a problem arises?* Find out what is covered and under what conditions in your policy. You may have to provide legal counsel on your own then be reimbursed or the insurance company may provide their own legal counsel directly to you. In some cases, if you refuse to settle a case, the company may no longer defend you.

In summary, read the policy and understand what it says. If anything seems different or is not clear to you from what the company representatives says, question it and keep careful records of all correspondence. Be sure your name appears on the policy.

How to avoid litigation

In the 1988 meeting of the American Pharmaceutical Association in Atlanta, malpractice experts discussed how pharmacists could avoid litigation. The concepts of law that are of primary concern to the courts and pharmacy relate directly to medical malpractice. The panelists identified several major areas.

1. ***Negligence*** refers to ir competence as measure against the standards, of th profession. It can also includ any harm that has come to th patient and a breach of leg duty to counsel or review a pa tients profile.
2. ***Strict liability*** encom passes the sale or dispensatio of a product which may caus harm.
3. ***Causation*** deals with th question of whether or not th error actually caused harr and was the error foreseeabl (proximate cause).
4. ***Nonfeasance*** is based o acts of omission such as nc counseling at all.
5. ***Misfeasance,*** according t the panel, is the most easil proven in that it involves er rors in dispensing, labelin and packaging.

Pharmacists traditionall were sued on the basis of ma feasance (e.g. wrong medica tions, wrong strengths, incor rect labels, a failure to us child resistant containers According to the panelist the most volatile area of ma practice today centers aroun the pharmacists failure t counsel. These cases are ex amined on an individua unique basis and are decide on whether or not a pharma cist has a duty to warn an when. The reason given fo the change is that as pharmac continues to evolve from a dis pensing function to a counse ing, consumer-oriented se vice, the courts are somewha behind in setting legal prece dents.

In a recent article by pha macist-attorney Frederic Fern, there are four element in which a plaintiff must prov in order to win a lawsuit. The include:

A) an owed duty to care by th pharmacist to the plaintiff,
B) a breach of that duty by th pharmacists action being be low the standard of care,

Continued on page IP

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Vons' integration of So. Calif. Safeways is 'well under way'

LOS ANGELES — Just over one year since acquiring Safeway's Southern California stores, Vons Cos. is now nearing total integration of the two grocery chains.

Combination of the two retailers "was, and is, an ambitious undertaking. . . and for Vons it was an important step in our strategic plan," Roger Stangeland, chairman and ceo, told analysts in Los Angeles recently.

Stangeland, noting the conversion of the 162 former Safeways is well under way, outlined steps Vons is taking to integrate the two operations.

- Total remerchandising. This process, which required resetting almost all of the shelves at the former Safeway stores, has been completed at all locations.
- Computer conversions. All Safeway store data processing and management systems have now been switched over to the Vons format.
- Store upgrading. The chain has made minor remodeling improvements this year in both acquired stores and existing units. Currently, 53 store upgrades have been completed and another 44 are in progress.
- Major remodels. Presently, the chain has completed or has underway the remodeling of some 20 former Safeway stores and nearly another 20 Vons stores.
- Manufacturing. Vons has already merged bakery operations of the two chains, and will concentrate on consolidating dairy and ice cream operations.
- Distribution. All warehouses have been reconfigured, with Vons looking to consolidate where it makes sense.

Consolidation efficiencies should bring considerable cost savings, Stangeland said. Sales are also expected to rise substantially, since they'll take on the aggressive, promotion-oriented flair of Vons.

Vons' financial status has already started to improve since the acquisition. Although still in the red, with a net loss of $8.8 million in the second quarter ended June 18, the company did see an improvement over the first quarter's $13.4 million loss, and last year's final quarter loss of $16.2 million.

Beyond consolidation, Stangeland said Vons continues to build its business strategy "around the operation of multiple store formats." Through varied store prototypes, store-specific merchandising and focused advertising, the chain is able to carefully target the region's diverse demographics, he said.

Currently, Vons is operating 234 Vons supermarkets, 70 Vons food and drug stores, 13 Pavilions, 11 Pavilions Place and seven Tianguis locations. The retailer looks to include pharmacies in all its remodeling and new store plans, according to Stangeland, who said: "The most potent format is the [combo] food and drug stores."

Strikes, reorganization crimp Fred Meyer's net

PORTLAND, Ore. — Protracted labor disputes and reorganization-associated costs caused Fred Meyer's net income to plunge 21.5 percent in '89's second quarter ended July 31, according to Frederick M. Stevens, chairman and ceo.

Net income reported was $7.4 million for the period, compared with last year's $10.6 million; income from operations fell from last year's $19.0 million to $14.9 million. Net sales were essentially flat: a 3.2-percent increase to $487.7 million was reported, with comparable-store sales up 1.2 percent.

Nine of the company's stores were affected by a recently-concluded 82-day strike against Seattle-area supermarkets. A second strike hurt central office, warehousing and transportation activity at the chain's headquarters here.

Wal-Mart's net, sales both up in 2nd qtr.

BENTONVILLE, Ark. — Results for Wal-Mart's second quarter ended July 31 showed sales increasing 25 percent to $6.046 billion and net income up 22 percent to $219.0 million. David Glass, president and ceo, cited service and high inventory levels as spurring performance.

Glass also announced that A. L. Johnson, who had retired earlier this year, has returned as vice chairman "to work with our Sam's Wholesale Club division."

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MARKET DIARY:

Largest Dollar Gainer	Warner-Lambert	$ 9.00
Largest Dollar Loser	Bolar Pharm., Scherer RP	$ − 2.00
Largest Percentage Gainer	Mylan Labs	36.13%
Largest Percentage Loser	Zenith Labs	−68.18%

Advances	39
Declines	14
Unchanged	5
New highs	20
New lows	4

	Close 9/26/89	Close 10/10/89	Net Change	Percent Change
Drug Store News Index	2886.55	3015.03	128.48	4.45
Dow Jones Industrial Average	2663.94	2785.33	121.39	4.56
Standard & Poor's 500-Stock Index	344.33	359.13	14.80	4.30
N.Y.S.E. Composite	191.47	199.00	7.53	3.93
Value Line Index	274.86	278.24	3.38	1.23

Source: Nordby International Inc., Boulder, Colo.

DRUG STORE NEWS INDEX

Exch	Company	Ticker Symbol	Closing Price 9/26/89	Closing Price 10/10/89	Net Change In Period	Percent Change In Period	P/E Ratio	Annual Dividend Rate	Annual Dividend Yield	Annual High	Annual Low
Chain store transactions											
OTC	Arbor Drugs	ARBR	21.75	21.75	0.00	0.00	23	0.16	0.74	24.75	8.00
OTC	Big B	BIGB	14.63	14.38	−0.25	− 1.71	16	0.16	1.11	15.25	10.63
OTC	Drug Emporium	DEMP	13.00	12.63	−0.38	− 2.88	18	0.05	0.40	16.25	6.38
NYS	Fay's Inc.	FAY	13.38	12.88	−0.50	− 3.74	17	0.20	1.55	15.00	8.63
ASE	Genovese Drug	GDX.A	11.13	11.25	0.13	1.12	16	0.24	2.13	12.88	8.75
OTC	Leroy Pharmacies (H)	LERYW	4.63	4.63	0.00	0.00	—	0.00	0.00	5.50	4.38
NYS	Longs Drug Stores (H)	LDG	43.00	44.75	1.75	4.07	16	0.96	2.15	46.00	33.63
OTC	Medicine Shoppe (H)	MSII	29.88	32.25	2.38	7.95	25	0.10	0.31	32.25	20.25
NYS	Perry Drug	PDS	9.88	9.88	0.00	0.00	247	0.00	0.00	13.50	5.25
NYS	Rite Aid Corp. (H)	RAD	39.13	40.88	1.75	4.47	18	0.82	2.01	41.13	29.13
NYS	Walgreen Co.	WAG	44.00	48.25	4.25	9.66	19	0.68	1.41	50.25	29.63
Wholesaler's transactions											
OTC	Alco Health Services	AAHS	23.25	22.75	−0.50	− 2.15	16	0.00	0.00	30.38	19.50
ASE	Bergen Brunswig (H)	BBC	26.13	26.88	0.75	2.87	15	0.32	1.19	27.25	15.70
OTC	Bindley Western Ind. (H)	BIND	9.75	10.38	0.63	6.41	20	0.00	0.00	10.63	6.63
OTC	Cardinal Distribution (s)	CDIC	20.25	22.50	2.25	11.11	18	0.08	0.36	22.50	12.75
OTC	Durr-Fillauer	DUFM	21.38	22.25	0.88	4.09	22	0.24	1.08	23.25	15.38
ASE	Ketchum (L)	KCH	4.63	4.63	0.00	0.00	d	0.00	0.00	7.63	4.38
NYS	McKesson Corp.	MCK	37.13	37.38	0.25	0.67	16	1.44	3.85	39.75	29.63
ASE	Moore Medical	MMD	13.75	12.63	−1.13	− 8.18	d	0.00	0.00	15.63	9.00
NYS	Owens & Minor	OMI	11.88	11.88	0.00	0.00	19	0.26	2.19	15.88	11.25
Manufacturer's transactions											
NYS	Abbott Labs (H)	ABT	61.38	68.13	6.75	11.00	19	1.40	2.06	68.50	44.13
NYS	American Home Products (H)	AHP	99.00	106.63	7.63	7.70	16	3.90	3.66	107.25	76.38
NYS	Baxter International	BAX	22.38	23.38	1.00	4.47	17	0.56	2.40	24.38	16.25
ASE	Bolar Pharmaceutical	BLR	21.50	19.50	−2.00	− 9.30	12	0.04	0.21	32.25	16.75
NYS	Bristol-Myers Squibb	BMY	50.13	54.50	4.38	8.73	18	2.00	3.67	54.50	41.38
NYS	Carter-Wallace (H)	CAR	54.50	56.63	2.13	3.90	18	0.82	1.45	56.63	38.13
ASE	Forest Labs (H)	FRX	37.13	40.00	2.88	7.74	33	0.00	0.00	40.38	21.63
ASE	Halsey Drug	HDG	6.06	6.13	0.06	1.03	20	0.00	0.00	7.38	2.38
NYS	ICN Pharmaceutical	ICN	5.75	6.00	0.25	4.35	67	0.00	0.00	7.25	5.63
ASE	Lee Pharmaceutical (L)	LPH	3.13	3.00	−0.13	− 4.00	d	0.00	0.00	5.38	2.75
ASE	Leiner P. Nutrition	PLI	20.38	20.63	0.25	1.23	17	0.00	0.00	21.38	10.00
NYS	Lilly Eli Co. (H)	LLY	60.00	65.75	5.75	9.58	22	1.35	2.05	66.25	42.25
NYS	Marion Labs	MKC	34.38	34.63	0.25	0.73	24	0.36	1.04	36.50	16.75
NYS	Merck Co. (H)	MRK	71.13	77.75	6.63	9.31	23	1.80	2.32	78.00	53.50
NYS	Mylan Labs (H)	MYL	14.88	20.25	5.38	36.13	47	0.10	0.49	20.63	7.50
OTC	Newport Pharmaceutical	NWPH	4.38	4.44	0.06	1.43	d	0.00	0.00	6.63	1.75
NYS	Par Pharmaceutical	PRX	5.88	5.50	−0.38	− 6.38	10	0.04	0.73	12.50	3.88
NYS	Pfizer Inc.	PFE	66.38	68.63	2.25	3.39	16	2.20	3.21	70.75	54.00
NYS	Robins, A.H. (H)	RAH	31.88	34.88	3.00	9.41	16	0.00	0.00	35.00	21.88
NYS	Rorer Group	ROR	43.63	44.50	0.88	2.01	22	0.80	1.80	48.25	36.13
OTC	Scherer RP Corp. (L)	SCHC	13.50	11.50	−2.00	−14.81	—	0.40	3.48	33.38	11.50
NYS	Schering Plough (H)	SGP	73.75	78.50	4.75	6.44	20	1.80	2.29	79.63	52.50
NYS	Syntex Corp.	SYN	45.25	47.25	2.00	4.42	18	1.50	3.17	54.50	36.50
NYS	Thiokol Inc.	TKC	14.50	15.25	0.75	5.17	17	0.30	1.97	125.00	12.38
NYS	Upjohn Co.	UPJ	37.38	39.38	2.00	5.35	20	1.00	2.54	42.00	27.00
NYS	Warner-Lambert (H)	WLA	106.50	115.50	9.00	8.45	21	2.56	2.22	116.00	70.75
NYS	Zenith Labs (L)	ZEN	1.38	0.44	−0.94	−68.18	d	0.00	0.00	2.75	0.38
Other retailer transactions											
NYS	Albertson's (H)	ABS	53.25	59.75	6.50	12.21	22	0.80	1.34	59.75	32.75
NYS	American Stores	ASC	62.25	64.63	2.38	3.82	28	1.00	1.55	72.50	51.50
NYS	Giant Food	GFS.A	31.50	30.88	−0.63	− 1.98	18	0.50	1.62	36.25	21.00
NYS	K-Mart	KM	39.25	38.50	−0.75	− 1.91	10	1.64	4.26	44.88	33.75
NYS	Kroger	KR	18.25	18.50	0.25	1.37	d	0.00	0.00	58.38	8.38
NYS	Melville Corp.	MES	48.63	52.00	3.38	6.94	16	1.30	2.50	53.63	34.38
OTC	Fred Meyer	MEYR	19.63	21.63	2.00	10.19	16	0.00	0.00	23.00	14.25
NYS	Penney, JC	JCP	68.13	68.00	−0.13	− 0.18	11	2.24	3.29	68.75	50.38
NYS	Smith's Food & Drug (H)	SFD	24.75	24.63	−0.13	− 0.51	23	0.20	0.81	25.00	20.50
NYS	Wal-Mart (H)	WMT	39.63	43.75	4.13	10.41	27	0.22	0.50	44.00	29.25

Key: (H) = New high in period. (L) = New low in period. (d) = Deficit. NYS = New York. ASE = American. OTC = Over the counter. (s) = Reflects stock split.

Notes: Bristol Myers acquired Squibb and the merge results in a new company called Bristol-Meyers Squibb. Our Chart reflects this change accordingly. Also, Dart drug stores was delisted from NASDAQ and has been removed from our list. Cardinal distribution split 5-for-4.

Source: Nordby International, Inc., Boulder, Colorado